Volume 4:

Quality Management
and
Grievance and Appeals

TABLE OF CONTENTS

VOLUME 4: QUALITY MANAGEMENT AND GRIEVANCE & APPEALS

QUALITY MANAGEMENT

a.1. Quality Management Function and Structure 1

a.2. Performance Improvement Model 4

a.3. Stakeholder Involvement 6

a.4. Accreditation and Contract Fulfillment 8

a.5. Communication of Quality Management Information 9

a.6. Using Information to Identify Improvement Areas 11

a.7. Timeliness and Completeness of Data 13

a.8. Process and Focus of Provider Monitoring and Performance Improvement Activities 16

a.9. Utilization Management Function and Structure 19

a.10. Utilization Monitoring 24

GRIEVANCE & APPEALS

b.1. Notice Requirements 27

b.2. Grievance and Appeals Function 29

b.3. Grievance and Appeals Process 31

a.1. Quality Management Function and Structure

There has been tremendous growth and development in the Maricopa County behavioral health system since 1999, when ValueOptions became the Regional Behavioral Health Authority (RBHA). We have expanded services and programs across all populations, managed the influx of Medicaid enrollees, reformed the philosophy of the delivery system to conform to the Arizona principles and the Child and Family Team process, developed an infrastructure to manage consumer and program growth, introduced evidence-based practices, improved access to care for Latino youth, and added capacity to our Direct Service Sites. Major strides have been made in improving the overall quality of services. The quality management (QM) model in place during this period focused on measurement, reporting, and corrective action. It did not require centralized approval of decisions pertaining to quality and did not promulgate a uniform approach to quality improvement or coordinate actions to improve quality.

During this contract period, ValueOptions will be implementing a new model of quality improvement. Implementation begins with the centralization of oversight of the QM process, a redesigned Quality Management (QM) Department, the development of a QM/UM committee structure with clearly defined decision points, and the orientation and training of management staff in the area of continuous quality improvement. As the model is implemented, it orients and trains staff and providers in the model, establishes decision-making rules, and as staff, providers, and consumers and families are trained develops a bottom-up, highly participative model of quality improvement. Throughout this process, the QM/UM function will continue to ensure that all Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) requirements are met.

This model is described in more detail in *Volume 4a.2 and 4a.3*. This section describes the function and structure that will support it as it is implemented.

Function and Structure

The Quality Management (QM) Department has responsibility to ensure compliance with the required ADHS/DBHS performance standards, as well as responsibility for coordination, supervision, and support of quality improvement activities across administration, Direct Service Sites, and contracted providers. The primary goals of the quality improvement process are to:

- assure uniform, integrated monitoring of program performance for both contracted providers and Direct Service Sites;
- analyze our success in achieving desired consumer outcomes and in complying with the required performance standards and report information to the QM/UM Committee to assist in selection of performance improvement initiatives across the service delivery system;
- facilitate and support the ongoing performance improvement process; and
- protect consumer rights.

To meet these responsibilities, ValueOptions will restructure the Quality Management Department into four interactive teams: System Monitoring; Analysis, Evaluation, and Special Studies; Performance Improvement; and Consumer Rights and Legal Services.

All four teams report to the VP (VP) of Quality Management and collaborate with each other to support system-wide quality improvement efforts. The following paragraphs describe the number and qualifications of the staff who carry out these functions under each heading below. Please see *Volume 1f.* for the full organization chart of the QM Department.

Oversight through the Vice President of Quality Management. The VP of Quality Management supervises RBHA quality management activities, including the joint development with the VP of Clinical Operations of a draft Quality Improvement Plan, which is a component of the agency QM/UM Plan. This quality improvement plan will describe the process for implementing the quality improvement model, including structure, roles, responsibilities, annual goals, timeframes, communication plan, training requirements, and evaluation of results achieved. After input from advisory committees, this plan is ultimately approved by the Executive Management Team. The VP of Quality Management will have at least five years of experience in quality management and managed behavioral health care and an advanced degree in a behavioral health field. One FTE Administrative Assistant, with five years of related experience, will provide support to the VP. The Vice President supervises the following teams:

The Provider Monitoring Team reports to the VP of QM and performs or directs all RBHA quality management performance monitoring activities of all contracted providers and Direct Service Sites. The team performs quarterly desk audits, annual site visits, and ad hoc focused reviews, including QM provider-monitoring activities related to the Arnold v. Sarn Exit Stipulation and the J.K. Settlement Agreement.

Staff includes: one full-time equivalent (FTE) Manager of Provider Monitoring with three years management experience in behavioral health quality management and/or management experience in clinical behavioral health services, Master's degree required; eight FTE Quality Management Specialists, with three years experience in behavioral health services, Master's degree or Registered Nurse (RN) preferred, and certification in behavioral health; and one FTE Administrative Assistant, with three years related experience.

The Analysis, Evaluation, and Special Studies Team of the Quality Management Department reports to the VP of Quality Management. The team uses data validation, statistical analysis, and quality management technologies, such as statistical process control charts, to convert data into meaningful information that demonstrates trends, variance from standards, outliers, and opportunities for improvement. The team presents the information to the QM/UM Committee. The team serves as a resource for other parts of the organization that need assistance with evaluating data validity and converting it to useful information. They assist other staff in recommending standards and data collection tools and assist in evaluating that data to obtain information about performance. Examples of reports that the team receives for analysis include utilization reports and studies, results of external and internal audits and reviews, complaints and grievances, results of Performance Improvement Activities (PIAs), and internal management reports.

Staff includes one FTE Manager of Reporting and Analysis, Master's degree preferred, with three years experience in basic statistical analyses and preparation of reports for executive management in behavioral health; one FTE Manager of Special Studies, Master's degree required, with three years experience in outcome evaluation research and two years of supervisory experience; two FTE Quality Management Specialists, Master's degree preferred, certification or RN required, with two years experience in clinical services or quality management; and two FTE Data Specialists, with at least two years of related experience.

The Performance Improvement Team reports to the VP of Quality Management and provides technical assistance, support and coordination of RBHA performance improvement activities. The team is a resource center for expertise in quality improvement technologies and implementation of performance improvement activities to ensure attainment of desired outcomes across the service delivery system and within ValueOptions operations. The team provides technical assistance, support, and training to staff doing Performance Improvement Activities (PIAs). ValueOptions encourages and trains all staff to identify opportunities for improvement and to implement them according to the FOCUS PDCA model (see *Volume 4a.2.*) within the context of the Annual Quality Management Plan and the defined supervisory process. The Quality Management Department performance improvement team tracks all completed PIAs and reports findings, actions, and recommendations to the QM/UM Committee for their final review and approval.

Staff includes one FTE Manager of Performance Improvement, with specialized skills and at least two years of experience in performance improvement and in behavioral health programs, services, and operations; two FTE Lead Clinical Investigators with specialized skills in performance improvement, with at least one year of experience in behavioral health programs, and nursing licensure in Arizona; two FTE Performance Improvement Specialists, Master's degree preferred, with at least two years experience with Medicaid service delivery; and one FTE Performance Improvement Coordinator, Bachelor's degree preferred, or at least three years experience with quality management practices.

The Consumer Rights and Legal Services Team reports to the VP of Quality Management and manages consumer grievances and appeals; provider appeals; risk management, including incidents, mortalities and the use of seclusion and restraint; HIPAA Privacy compliance; and RBHA legal issues related to contractual requirements. The team coordinates with ValueOptions' Corporate Legal Counsel, Corporate Regulatory Compliance staff, Corporate Risk Management staff, ADHS/DBHS Office of Human Rights staff, the Maricopa Human Rights Committee, and external Legal Counsel and is responsible for the three units listed below.

Staff includes one FTE Director of Consumer Rights and Legal Services with three years experience in related areas and/or behavioral health care, and Arizona licensure as an attorney preferred; one FTE Legal Counsel for the RBHA, with Arizona licensure as an attorney with behavioral health experience preferred, and one FTE Administrative Assistant, with at least three years of administrative experience.

The Grievances and Appeals Unit reports to the Director of Consumer Rights and Legal Services and manages RBHA Grievance and Appeals operations in accordance with ADHS/DBHS requirements. The unit manages the monitoring, reporting, and resolution of consumer grievances and appeals, as well as provider appeals.

Staff includes one FTE Manager of Grievances and Appeals with either an Arizona State Bar License in good standing or certification as an Arizona Paralegal and two years as a practicing attorney or paralegal; one FTE Attorney with appropriate certification and licensure in Arizona, in practice for a minimum of two years; one FTE Grievance and Appeals Operations Manager, with a Bachelor's degree and five years of related experience; one FTE Lead Grievance Coordinator, with a Bachelor's degree and three years of related experience; one FTE Investigator, Bachelor's degree preferred in a related field and two years of experience; five FTE Appeals Coordinators, Bachelor's degree in a related field preferred, and one year of related experience; and two FTE Administrative Assistants with three years of clerical experience.

The HIPAA Privacy Unit reports to the Director of Consumer Rights and Legal Services and directs and oversees RBHA compliance with HIPAA and regulatory requirements.

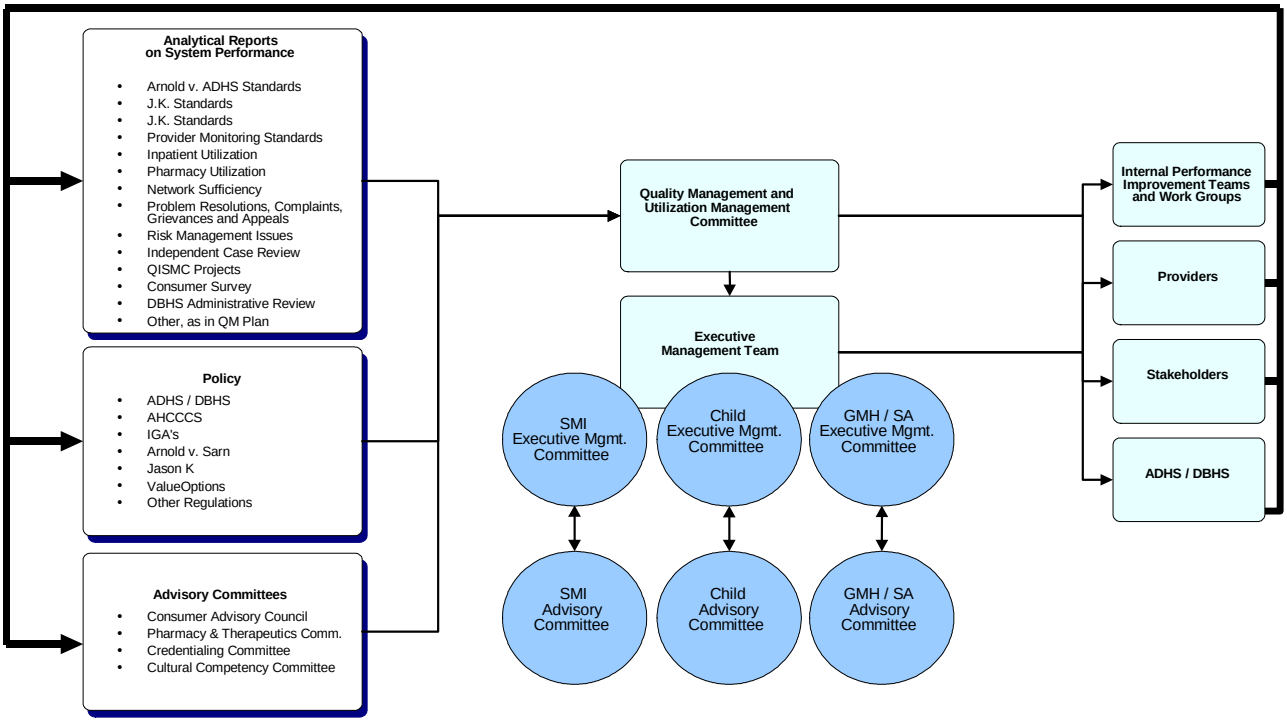
Staff includes one FTE HIPAA Privacy Officer, Bachelor's degree required, with one year of experience in behavioral health regulatory functions; one FTE Manager of HIPAA Compliance, Master's degree preferred, with five years of experience in regulatory behavioral health; and one FTE Administrative Assistant, with three years of administrative experience in behavioral health.

The Risk Management Unit reports to the Director of Consumer Rights and Legal Services and manages RBHA risk management operations in accordance with ADHS/DBHS requirements.

Staff includes one FTE Manager of Risk Management, Bachelor's or RN preferred, with at least two years of experience in risk management; one FTE Psychiatric Nurse, with Arizona licensure and at least one year experience in behavioral health; three FTE Risk Management Specialists, Bachelor's or RN preferred, with at least one year of experience in behavioral health; one FTE Court Coordinator, with at one year experience in legal processes, behavioral health experience preferred; and four FTE Data Specialists, with at least two years of related experience.

Supported by the QM department, ValueOptions staff and providers, consumers and stakeholders come together to perform QM/UM activities according to the following functional structure which will be explained in *Figure 4a.2.* which follows:

Figure 4a.2
Overview of Quality Management Process



a. 2. Performance Improvement Model

As described in the introduction in *Volume 4a.1*, ValueOptions is in a time of transition in its quality management system. The model that has been in place for a number of years now needs to be revised to a model that will work better within the context of a much larger and more complex system than the one that existed in 1999.

F – Find an opportunity
O – Organize a team of key personnel
C – Clarify the goal
U – Understand sources of variation & identify strengths
S – Select the improvement

P – Plan the improvement
D – Do the improvement
C – Check the results
A – Act to hold the gain

During the next contract period, ValueOptions will implement the FOCUS PDCA performance improvement model, outlined in the figure to the right. It is a strengths-based model, selected for its similarity to the focus of the ADHS/DBHS and ValueOptions strengths-based treatment planning model. Indeed the goal is to have the performance improvement model, system operations, and individual treatment planning following similar processes to achieve goals. At that point, consumers and their families will be fully empowered to not only make decisions about their treatment but also to participate in improving the daily operation of services.

To improve communication and coordination across all departments during the next contract term, ValueOptions will define clear points of responsibility for specific types of quality management and utilization management decisions; and will create a structure that supports implementation of the performance improvement model across all parts of the organization, that facilitates formal and informal participation by consumer, family members, providers, and stakeholders; encourages identification of opportunities for improvement by all staff; and will ensure that feedback loops and monitoring activities produce data that is valid and presented as meaningful information.

The **Executive Management Team** (EMT) meets monthly to review QM/UM results and to make decisions about policies, strategies for implementing policy, strategic initiatives, priorities for the Quality Management and Utilization Management (QM/UM) Committee, and to approve the QM/UM Plan, including what information the RBHA will focus on to document system change. This committee is responsible for articulating the vision and overall purpose for all QM/UM activities and the performance improvement model that will be used in all performance improvement activities. The EMT consists of the core executive management staff from all ValueOptions departments.

The **Quality Management/Utilization Management Committee** meets monthly, more frequently as needed, to make decisions about: information it will require for QM/UM activities, regular reports and specific drill-down reports for specific projects; specific areas for performance improvement actions across the service delivery system or with specific populations and results expected; training requirements; and results achieved by the Population-specific Management Committees. The QM/UM Committee is composed of senior staff from all ValueOptions departments. Staff will join the committee as required for specified agenda items.

The three **Population-specific Management Committees** meet at least monthly. They are operational committees but receive direction from the QM/UM Committee and report results back to the QM/UM Committee. The three Population-specific Management Committees are the SMI Committee; the General Mental Health and Substance Abuse Committee; and the Children's Committee. Each Population-specific Management Committee:

- operationalizes policies and strategic initiatives across all departments for its specific population;
- implements performance improvement actions to achieve the results defined by the QM/UM Committee for its specific population or directs staff who report to them to do so;
- acts on input from the appropriate Population-specific Advisory Committee, and briefs it on PIAs implemented and results achieved as described in *Volume 4 a.3*;
- reports on the results achieved and input from the appropriate Population-specific Advisory Committee to the QM/UM Committee through the QM Department,
- monitors PIAs initiated at the staff level to ensure use of resources consistent with strategic goals. Arranges technical assistance as needed from Quality Management Department and ensures results are reported to the QM department, and
- coordinates activities that involve more than one population with the other two population specific committees through the chair, who is the same for all three committees.

Each Population-specific Management Committee is composed of the Chief Clinical Officer who chairs the committee, Chief Medical Officer, Chief Clinical Officer, Chief Administrative Officer, Chief Financial Officer, VP of Quality Management, VP of Programs/Direct Services, Executive Director of Pharmacy, VP of Network Management and Program Development, VP of Clinical Operations, and the Chief Technology Officer and additional RBHA staff who relate to the populations served (e.g., network staff specializing in children's providers would attend the Children's Committee). Staff who are participating in PIAs may attend this committee or discuss issues with their supervisor to bring to this committee. These three committees are necessary because, operationally, services for the three populations are structured very differently. Staff and providers responsible to implement PIAs either work for or are contractually responsible to one of the members of these committees.

The QM Department. The VP of Quality Management and the Quality Management Department play an essential supporting role to the above committees by validating and analyzing all QM/UM data to determine its meaning. All data concerning topics in the RBHA QM/UM Plan are directed to the QM Department to be assessed and converted into information. The VP of Quality Management ultimately decides if the data is valid and ensures that it is sufficiently analyzed to enable the QM/UM Committee to be presented with meaningful information.

Decision Points. The final responsibility for committee decisions rests with the committee chairperson and the Vice President of QM:

- Executive Management Team—Chief Executive Officer;
- QM/UM Committee—Chief Medical Officer;
- Population-specific Management Committees: SMI, GMH and Substance Abuse, and Children's Services—Chief Clinical Officer (for all three committees); and
- Data Validity and Analysis—VP of Quality Management.

A unifying core group of managers attends the Executive Management Team, QM/UM Committee, and three Population-specific Management Committees. This core group ensures cross-departmental input and involvement in all decisions regarding all program areas.

Reporting Committees.
Committees that report to the QM/UM Committee include the **Pharmacy and Therapeutics Committee** and the **Credentialing Committee**:

- The Pharmacy and Therapeutics Committee develops, revises, updates, implements, and monitors the ValueOptions medication formulary and medication-related practices, policies and procedures. The Committee, which meets quarterly, is composed of the Chief Medical Officer (Chair), RBHA Pharmacy staff, and prescribers and pharmacists who practice in the system.
- The Credentialing Committee manages the credentialing, recredentialing, and privileging as appropriate, of all network providers in accordance with ADHS/DBHS requirements. It meets monthly and is composed of the Chief Medical Officer (Chair), Chief Clinical Officer, VP of Clinical Operations, VP of Network Management and Program Development, Director of Network Operations, VP of QM, and Provider Representatives (minimum of seven)

Implementing the above structure will require extensive training throughout the system and possible staffing enhancements in the QM Department. The core group of managers who attend the Executive Management Team, QM/UM Committee, and the three Population-specific Management Committees must be the first to be well trained in application of the FOCUS PDCA process and to advocate for its use in every part of the organization.

PIA teams assembled by the Population-specific Management Committees will initially all need technical assistance and mentoring provided by the QM Department Staff. The QM/UM system and practical application of the FOCUS PDCA model will be a part of the regular curriculum developed by the training department for all new hires and for contracted providers. As more and more teams successfully achieve their goals, a growing reservoir of staff will have expertise in using the FOCUS PDCA model and can be resources to their colleagues.

Eventually all staff will be familiar with strengths based processes to achieve goals and use them routinely in service planning and quality improvement. At that point most Quality Improvement (QM) initiatives will be generated from line staff, consumers and family members. Consumers and family members will regularly participate in Performance Improvement Activity teams and the formal QM/UM structure will primarily coordinate activities, ensure strategic use of resources to accomplish DBHS objectives and document accomplishments.

a. 3. Stakeholder Involvement

One of ValueOptions' highest priorities is to involve stakeholders, providers, consumers, family members, ValueOptions personnel and external experts in the ongoing development and operations of our Quality Management (QM) Program. Consumers and their families are the reason for our existence. We need their input during all aspects of the performance improvement process. The stakeholders who serve and advocate for consumers and families also offer alternative perspectives and valuable insights into system operations. We plan to continue our partnerships with consumers, families, and other stakeholders as part of our QM program while we train personnel and contracted providers to implement the FOCUS PDCA model. The goal of the quality improvement system is to develop a self-correcting service delivery system, including the contracted providers and direct service providers staffed by ValueOptions personnel, who will use data to identify areas for improvement, and will coordinate with others in the work process to make lasting, positive change

The QM Department, in consultation with the Director of Marketing and Public Affairs, will develop a detailed plan for communication of the ValueOptions quality improvement effort to consumers, family members and stakeholders. An internal communications plan will also be developed in consultation with the VP of Strategic Planning and Director of Operational Integration to communicate information to ValueOptions staff. The initial goal of the communication effort will be to inform consumers, families, ValueOptions staff, and other stakeholders about the strategic vision for the quality improvement effort, the process and model that will be used, the way that areas for improvement will chosen, the structure for the process, estimated time frames, and how recommended changes will be implemented. Consumers, family members, providers and other stakeholders will be asked their preference for making contributions to the process.

The Performance Improvement Activity (PIA) Teams themselves will include individuals who are directly involved in the process under scrutiny. Individual consumers, family members, personnel, providers or stakeholders, in varying combinations based on area being addressed, will also be included on the performance improvement team. These individuals will provide feedback during the data collection phase of the team process, assist in the implementation phase, and help evaluate system changes or make recommendations for subsequent process improvement efforts. The QM staff will provide technical assistance and training initially and will use information gathered during these activities to fully refine how consumers, families and stakeholders will be involved in all aspects of quality improvement.

ValueOptions will develop tools or establish forums to obtain information from consumers, families, staff and other stakeholders during the performance improvement process. In addition, we will continue to use current feedback tools as components of the information reviewed to identify possible areas for improvement.

ValueOptions uses the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) **Behavioral Health Recipient Satisfaction Survey** as a source of information about consumer and family member perceptions of the strengths of the service delivery system, as well as a source for identifying opportunities for improvement within the system. The Survey results inform the QM Program regarding: overall satisfaction with the services provided; access to care; participation in treatment planning; the appropriateness and quality of services; the outcomes of services; the cultural sensitivity of services; and other open-ended issues which may be identified by survey respondents. In addition, ValueOptions actively pursues the guidance of stakeholders, behavioral health recipients, and family members through presentation of survey results to various Advisory Committees so their input can assist in the selection of targeted performance improvement plans.

Within the service delivery system for persons with serious mental illness, ValueOptions implemented the **Consumer Report Card,** which is a survey that is conducted by and for consumers, capturing their evaluation of their own recovery efforts as well as the helpfulness of ValueOptions staff in a variety of areas. This information is SMI direct services provider clinic specific and is sent monthly to providers to identify opportunities for improvement and track results achieved. The Consumer Report Card currently applies to the services directly operated by ValueOptions, but will be expanded in 2004 to apply also to the services offered by contracted providers in the community.

ValueOptions produces quarterly **Trending Analyses of Problem Resolutions, Grievances and Appeals.** These reports will be analyzed for patterns, trends and outliers and will be sent to relevant departments or providers and reviewed by the QM/UM Committee, which will use them to direct PIAs as necessary to improve systemic performance.

Advisory Committees have two functions: advising ValueOptions about policy, needed actions, and unintended consequences of actions under consideration; and learning about RBHA actions and policies and representing them

accurately to the community. The following three **Population-specific Advisory Committees** meet monthly and otherwise as needed and are composed of consumers, family members, advocates, providers, and external experts:

- The **Advisory Committee for Serious Mental Illness,** for services to consumers with serious mental illness;
- The **Advisory Committee for Children's Services,** for services to child and adolescent consumers and their families;
- The **Advisory Committee for General Mental Health and Substance Abuse**, for services to general mental health and substance abuse consumers.

Members of the corresponding Population-specific Management Committees facilitate the meetings. Facilitators are responsible for reporting input and delivering minutes to the rest of the Population-specific Management Committee.

Policies and initiatives contemplated and actions taken by the Population-specific Management committee including QM/UM policies and initiatives and the QM/UM plan are reported for review and comment. The three Committees hold a joint meeting semiannually to advise ValueOptions on RBHA-wide issues. A key distinct function of the Committees is to advise on training needs for each population.

The **Cultural Competency Committee** is co-chaired by the Chief Executive Officer and the VP for Network Management & Program Planning. The committee leads efforts to embed cultural competence into the behavioral health system and its programs by providing leadership, engaging the community's participation, and identifying clinical tools for organizations and individual clinicians. The Committee meets monthly, and otherwise as needed, and includes representation from a variety of stakeholders and external experts.

ValueOptions actively and successfully seeks **Consumer and Family Member Employees** in service delivery and administration functions. They offer unique insights into the needs and concerns of consumers and family members, and also bring valuable perspectives to quality improvement and implementation efforts.

ValueOptions will continue to solicit information and involvement through the following committees, councils and boards that involve consumers, providers, stakeholders, external experts, or family members:

Committee or Board	Chair	Meets	Reports to	Which groups are included
Community Advisory Board	Chief Executive Officer	Quarterly	Chief Executive Officer	Community stakeholders, clinicians, consumers, and their family members
Maricopa Consumer Advisory Council	Consumer Affairs Manager	Monthly	Chief Clinical Officer	Consumers, family members, consumer advocates, ValueOptions staff
Tenant Advisory Committee	Manager of Housing	Monthly	Housing Department	Consumers
Crisis Advisory Committee	Director of Crisis Services	Monthly	Director of Crisis Services	Police, Fire, Families, Consumers, Hospitals, Other crisis stakeholders
Pharmacy and Therapeutics Committee	Chief Medical Officer	Quarterly and as needed	QM/UM Committee	Prescribers, Pharmacists, ValueOptions' staff
Prevention, Community Education and Outreach	PE&O Manager	Monthly	PE&O in Networks Department	Prevention Providers, Consumers
Credentialing Committee	Chief Medical Officer	Monthly and as needed	QM/UM Committee	Minimum of seven providers representing range of disciplines and cultural/ethnic groups, ValueOptions' staff

a. 4. Accreditation and Contract Fulfillment

ValueOptions currently operates two Service Centers that achieved the highest level of accreditation from the National Committee for Quality Assurance (NCQA), and twelve Service Centers that achieved accreditation from the Utilization Review Accreditation Commission (URAC). All corporate policies and procedures are designed to comply with NCQA standards, and most Arizona policies follow corporate standards.

ValueOptions will only seek national accreditation for the Maricopa County Regional Behavioral Health Authority if it is required to do so by the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS). The investment of resources required to attain and maintain national accreditation is one consideration in the decision; however, the most important consideration is that our reviews indicate that DBHS standards and contractual requirements establish a solid framework of clinical and programmatic accountability.

If in the future DBHS should require accreditation, and should there be any conflicts between contractual requirements and accreditation standards, ValueOptions will honor and adhere to the DBHS contractual requirements. We would notify DBHS of any conflicts and follow the Department's guidance regarding changes in policies or procedures.

a. 5. Communication of Quality Management Information

ValueOptions recognizes that the effective and efficient operation of the service delivery system, and of the Regional Behavioral Health Authority (RBHA), cannot exist without complete, accurate and timely communication and dissemination of information. This communication must occur with the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS), internally throughout all RBHA departments, and with our contracted and direct service providers, external stakeholders, consumers, and families. Plans for such communication are described in *Volume 1k and 1n*. The following table and paragraphs present our communication plans specific to Quality Management (QM) information.

Item Disseminated	Recipient	Communication Method
1. Annual Report	ADHS/DBHS, providers (contracted and ValueOptions direct service), RBHA staff, all advisory committees, all interested parties	Web site, hard copy, disk, electronic copy, facsimile
2. ValueOptions' annual QM/UM plan	ADHS/DBHS, providers (contracted and ValueOptions direct service), RBHA staff, all advisory committees, all interested parties	Web site, hard copy, disk, electronic copy, facsimile
3. ValueOptions' performance on external audits: court monitor & independent case review (ICR)	ADHS/DBHS, providers (contracted and ValueOptions direct service), RBHA staff, all advisory committees, all interested parties	Web site, hard copy, disk, electronic copy, facsimile
4. Provider notices	ADHS/DBHS, providers (contracted and ValueOptions direct service), RBHA staff	Web site, hard copy, disk, electronic copy, facsimile
5. ValueOptions' performance on ADHS/DBHS Practice Improvement Protocols (PIPs)	ADHS/DBHS, selected RBHA staff, selected providers	Hard copy, disk, electronic copy
6. ValueOptions' performance on ADHS/DBHS strategic initiatives	ADHS/DBHS, selected RBHA staff, selected providers	Hard copy, disk, electronic copy
7. ValueOptions' performance on specific ADHS/DBHS quality indicators	ADHS/DBHS, selected RBHA staff	Hard copy, disk, electronic copy
8. In addition to monitoring our own performance, we inform providers about their performance on provider-specific quality indicators	Relevant provider, selected RBHA staff	Face-to-face meetings with providers, training, technical assistance, written communications in hard copy and electronic copy

Communication with ADHS/DBHS

ValueOptions' communication with ADHS/DBHS regarding quality management information will be driven by the required deliverables, data sets, reports and information identified in: the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) Solicitation Number HP432188, Scope of Work Paragraph K, and Exhibit A; the ADHS/DBHS Policy and Procedures on quality management; the ADHS/DBHS Annual Quality Management Plan; the AHCCCS requirements outlined in AHCCCS Medical Policy Manual AMPM, Chapters 900 and 1000; and the ADHS/DBHS Provider Manual. Please refer to *Volume 4 a.6.* for a description of the deliverables, data sets, reports and information we will use, and to *Volume 4a.7* for a description of the methods we will use to ensure the delivery of complete, timely and accurate information.

In addition, ValueOptions will actively participate in the following ADHS/DBHS meetings, as described in the ADHS/DBHS QM/UM Plan for 2003–2004, to ensure the communication and dissemination of information: RBHA Chief Executive Officers Meetings; RBHA Medical Directors Committee; RBHA QM Coordinators Committee; RBHA Chief Financial Officers Meeting; RBHA Information Technology Services Meeting; RBHA Training Coordinators Meeting; and ADHS/DBHS Oversight Committee for Persons with Serious Mental Illness.

The ValueOptions QM/UM Plan will include a specific plan for communication and dissemination of quality management information between DHS, ValueOptions and Providers. ValueOptions staff will keep ADHS/DBHS informed of potential issues or complaints that may be forwarded to ADHS/DBHS.

Internal RBHA Communications
The Executive Management Team serves as the primary forum for communication and problem-solving with senior management staff for all RBHA operations. The Executive Management Team (EMT) receives performance results and outcomes for consumers and families served by the RBHA from the Quality Management and Utilization Management (QM/UM) Committee. The QM/UM Committee is the central clearing house for all QM/UM information from multiple sources. Each senior manager on the QM/UM Committee is responsible for receiving and communicating QM/UM information to his or her staff consistent with the internal communication plan. Developing and implementing an internal communication plan is the responsibility of the VP for Strategic Planning and his/her staff. This plan includes sharing with all staff QM information, both about the program and plan and about areas of focus and accomplishments.

Communication with Contracted Providers
The Network Management and Program Development Department maintains ongoing communications with contracted providers regarding routine operational and contract activities including QM information. The Network Management and Program Development Department communicates with clinical operations departments of contracted providers and QM staff of contracted providers through face-to-face meetings, telephone communications, mail and electronic mail, and other methods, as appropriate.

The ValueOptions QM/UM Program produces a variety of production reports that are sent to and discussed with providers. These include the reports resulting from: Desk Audits; Annual Site Visits; Ad Hoc Focused Reviews; Quarterly Report Reviews; and Pharmacy Prescriber Reports. Reference should be made to *Volume 4a.8* for a description of these reports and our related performance improvement activities.

ValueOptions holds the following regular meetings which include communication and dissemination of QM information:
QM Coordinators Meeting, monthly, with contracted provider QM Coordinators and Clinical Directors;

- CEO Meetings, monthly, with the CEOs of major contracted providers; and
- Provider Forums, monthly, with contracted providers and other stakeholders.

Communication with ValueOptions Direct Service Staff
Because ValueOptions Direct Service Sites are part of the RBHA, quality information is communicated to Direct Service Site staff through the reporting relationship to the Chief Clinical Officer and through participation on the Population-specific Management Committees for Serious Mental Illness. In addition, the VP of Programs/Direct Services is a member of the core group of Managers, which participates in all operational management committees, and will communicate findings to direct services staff. The VP of Programs/Direct Services receives recurrent reports and provider specific reports in the same manner as the contracted providers.

Communication and coordination between networks, clinical operations/utilization management and quality management is essential. Since there is a system in Maricopa County with two sets of providers for the SMI population, contracted and direct service, communication is especially important and challenging. The head of the departments communicating with providers about QM information all report to the Chief Clinical Officer and the population specific management committees are the forum in which networks, clinical operations, direct services and Quality Management all come together to make sure information is shared, actions are coordinated and the message is consistent.

Committee Participation
ValueOptions' three Population-specific Advisory Committees ensure the communication and dissemination of information both to and from consumers, families, providers, advocates, external experts, and to the community at large. These Advisory Committees meet monthly, review the QM/UM Plan, results of independent audits, advise ValueOptions about quality concerns and training needs. Providers also participate in other committees such as crisis services advisory committee, pharmacy and therapeutics and credentialing each of which reviews quality management information. Each Committee distributes written minutes to each committee member.

Communication is a two-way street—ValueOptions receives information about quality concerns and suggestions for improvement from DBHS, Advisory Committees, Customer Service Department, Complaints, Grievances and Appeals, and a telephonic "Suggestion Box," which anonymous callers may call to suggest quality improvements for the delivery system. Telephonic messages are recorded anonymously and Customer Service staff transcribe suggestions and present them to the QM Department for trending and analysis. The QM Department submits findings to the QM/UM Committee for action.

a. 6. Using Information to Identify Improvement Areas

Using information to identify opportunities for improvement is a way of thinking, an approach that can be applied to any situation. ValueOptions will train all staff and providers to understand and will expect them to use this way of thinking in both treatment planning and quality improvement. In treatment planning, the data sets/reports are the consumer's goals and whether they are achieved. In Quality Management, the data sets/reports are the organization's goals and their state of achievement. Sources of goals are diverse but opportunities for improvement exist when goals are not consistently met or when staff, consumers or providers identify better or more efficient ways to achieve goals.

The sources that ValueOptions uses to select goals include the quality management and utilization management activity requirements identified in:

- the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) Solicitation Number HP432188, Scope of Work Paragraph K, and Exhibit A;
- the ADHS/DBHS Policy and Procedures on Quality Management;
- the ADHS/DBHS Annual Quality Management Plan;
- the AHCCCS requirements outlined in AHCCCS Medical Policy Manual AMPM, Chapters 900 and 1000; and
- the ADHS/DBHS Provider Manual.

Using input from advisory committees, the Quality Management system as a whole, and the above requirements, the Executive Management Committee decides the goals, the achievement of which will be one focus of the QM/UM system.

In accordance with ADHS/DBHS requirements, ValueOptions monitors the following for both Direct Service Sites and subcontracted providers: treatment services, rehabilitation services, medical services, family support, support services including case management, crisis intervention services, inpatient services, residential services, and behavioral health day programs.

Monitoring occurs at the following service sites: Level I Hospital, Level I Psychiatric Hospital, Level I Sub-acute Facility, Level II Behavior Health Residential, Level III Behavioral Health Residential, Outpatient Clinic, Therapeutic Foster Care Home, and Community Service Agency.

Using our own provider monitoring for both contracted and direct service providers, and the Independent Case Review (ICR), ValueOptions collects information that will be used to inform the QM/UM Committee about appropriateness of services and network sufficiency, performance in meeting cultural needs, identifying under/over utilization patterns, monitoring penetration rate among populations, sufficiency of services, the success of the assessment and planning process, and coordination of care especially with PCPs. Evaluation of focused initiatives, on-site record reviews, critical incidents and grievance and appeal information provide information about program quality issues. The QM Department and Pharmacy Department assembles provider profiles and trended data reports.

ValueOptions also collects, analyzes and reports on recovery outcome domains which will be expanded to:

- For persons with serious mental illness: percent living in their own house/apartment; percent currently employed or self-sufficient; and health and wellness for all providers to the SMI population.
- For children and adolescents: ValueOptions will collaborate with ADHS/DBHS to develop the outcomes and indicators to be targeted for the J.K. Settlement Agreement, but proposes to monitor: percent of children living with their families; percent demonstrating success in school; and percent not displaying delinquent behavior.
- For general mental health and substance abuse: percent with reduced substance abuse, percent currently employed, and percent not incarcerated.

The QM department, to identify patterns, trends and outliers, and to identify opportunities for improvement, analyzes data from additional sources:

- ADHS/DBHS Quality Improvement Standards for Managed Care (QISMC) Studies;
- ADHS/DBHS Administrative Review;
- ADHS/DBHS Behavioral Health Recipient Satisfaction Survey;

- Medical Care Evaluation (MCE) Studies;
- provider and Direct Service Site monitoring reviews;
- recommendations developed by ValueOptions Performance Improvement Teams;
- recommendations developed by ValueOptions Advisory Committees on Serious Mental Illness, Children and Adolescents, General Mental Health and Substance Abuse, and the Consumer Advisory Council; and
- additional Quality Management, Clinical Operations, Utilization Management, and Network Management data and reports as may be identified or required by ADHS/DBHS.

ValueOptions uses information from our internal monitoring, provider reviews, advisory committee minutes, special studies, and other research efforts, including input from management teams to determine the areas in need of improvement. The QM Department collects, and in some cases, originates the information described. The Analysis, Reports and Special Projects Team determines the validity of the data and applies QI technologies and statistical tools to identify trends, significant variance from standards or goals, or significant outliers. The QM Department synthesizes the information into useful reports for review by the QM/UM Committee. The reports will offer areas where performance opportunities exist, and will quantify opportunities in those areas, particularly in areas where organizational goals are not being achieved.

The QM/UM Committee, which includes a core group of executive management, will review the information and choose the improvement opportunities based on the QM/UM plan, strategic initiatives, other QM activities already in process, system performance problems, stakeholder input, and ADHS/DBHS strategic plans. The QM/UM Committee selects the focus for improvement activities and results expected and directs the QM Department staff to work with Population-specific Management Committee(s) or administrative departments to implement the process of performance improvement.

In most cases, Population-specific Management Committees are responsible for implementing performance improvement actions required by the QM/UM Committee, and for directing staff efforts in the implementation phase. Team members will be those closest to the opportunity so will usually not be committee members but will be staff who report to committee members or providers who are contractually obligated to committee members. If progress is not being made, the QM Department will provide technical assistance or training. Depending on the subject matter or expertise needed by the team, other ValueOptions Departments may also provide technical assistance and training. The Performance Improvement Team in the QM department is a resource for technical assistance in the performance improvement process and the quality improvement model adopted by ValueOptions. Initially, while the FOCUS PDCA Quality Improvement model is being initiated, the QM Department staff will be responsible to facilitate and support the performance improvement teams and to report progress to the QM/UM Committee. As staff members are trained, more teams achieve results and staff become familiar and proficient in the model, performance improvement teams will be facilitated by a member of the team. The performance team itself makes final recommendations to the Population-specific Management Committee, or can meet with the Population-specific Management Committee at any time, and is responsible for achieving expected results. Consumers and family members will participate on performance improvement teams.

Various departments, such as pharmacy and clinical operations, generate QM/UM data which is practitioner, provider and service site specific and is routinely sent to contract providers and direct service sites. These reports describe the practice of individual practitioners or providers and compare it to the group as a whole or to established goals or standards. While these reports are trended by the QM department and reported to the QM/UM Committee, it is expected that providers use these reports to identify outliers or practitioners that are not practicing consistent with the principles espoused by DBHS and take appropriate performance improvement actions. Providers' constructive use of these reports is evaluated through the provider monitoring process coordinated between the QM department, Clinical Operations Department, and the Network Management and Program Development Department.

As more staff members are trained in the FOCUS PDCA model and the philosophy of Quality Improvement, simple PIAs will be initiated and completed by staff using information discovered locally to fix local problems under direction of their supervisor. Sometimes these teams will include consumers or family members. Completed PIAs will all be reported to the QM department and to the QM/UM Committee.

a. 7. Timeliness and Completeness of Data

ValueOptions will continue to implement a comprehensive process for ensuring complete, timely, and accurate quality management and utilization management data that will pertain to all ValueOptions staff, including direct service provider, and to all contract providers. The QM/UM Committee directs the QM Department to define the data elements necessary to monitor the implementation of policies, strategic initiatives, and performance improvement initiatives adopted by ValueOptions. The QM Department is responsible for defining the standards for the completeness, timeliness, and accuracy for all data required by the QM/UM Committee. There are many sources of information to inform this process including the DBHS contract, DBHS Provider Manual, and the ValueOptions QM/UM Plan.

Training is provided to contracted providers, the direct service provider, and RBHA staff to inform them of what data is required and the standards for completeness, timeliness, and accuracy of data.

The VP of Clinical Operations and her designees provide regular training to the ValueOptions direct service staff, contracted providers, and other RBHA staff about UM data to be reported and standards for completeness, timeliness, and accuracy. RBHA staff members receive initial orientation training and follow-up focused training for staff members whose performance does not meet standards.

The ValueOptions QM Department provides information and training through the following means:

- Requirements for complete, timely, and accurate data are published as a part of the Annual Quality Management Plan, which is distributed to all members of the Executive Management Team and to all contracted and direct services providers. The Plan contains a section describing the data collection and reporting requirements in detail, including the data specifications, the procedures and timelines for reporting the data, and the standards for completeness, timeliness and accuracy.
- Requirements are also published in Provider Notices, as reminders and updates to the material presented in the Annual Quality Management Plan.
- Requirements are discussed in detail in monthly meetings of the Provider QM Coordinators, which include representatives from direct service providers. These meetings are led by the ValueOptions Quality Management Department, and are well-attended by provider QM coordinators and relevant RBHA staff. Each month, a different quality management requirement is the focus of a detailed presentation, during which specific guidance is presented to providers. Topics have included, for example, clinical documenting requirements for the ValueOptions Clinical Record Review, reporting requirements for Medical Care Evaluation Studies, reporting requirements for access to care, and reporting requirements for incidents and accidents.
- Completeness, timeliness, and accuracy requirements are monitored as a part of the Annual Provider Site Visit process.
- Completeness, timeliness, and accuracy requirements are also addressed in technical assistance initiated for individual providers or for direct service sites, as requested, or as opportunities for performance improvement are identified.

Specific actions to ensure completeness, timeliness, and accuracy vary whether data is submitted or entered by a contracted provider, a direct services provider, or RBHA staff:

Contracted Providers

To ensure complete and accurate data from contracted providers, ValueOptions' Information Systems Department implemented a data "scrubber" that reviews QM data for completeness and accuracy and sends back error files with explanations to providers to correct errors and resubmit the data. The QM department logs timeliness of submission of data by each contracted provider. Providers are reminded in advance and again if they are late in submitting data. Providers that are repeatedly late are referred to Networks department for contract enforcement. Contracted providers submit UM data telephonically to UM staff. Methods to ensure completeness, timeliness, and accuracy of UM data therefore, vary according to the level of care:

For **contracted providers** providing **adult acute levels of care**:

- Care Managers conduct on-site reviews daily of persons admitted to a hospital.
- There is a daily reconciliation of the inpatient census with the actual authorizations.
- The Director of Clinical Services conducts monthly audits of inpatient service denials to ensure accuracy of documentation.

- Care Management conducts biannual audits of Level I clinical records to verify the information cited in certification and recertification of need.

For **contracted providers** providing **adult residential services**:
- Care Managers conduct on-site reviews of clinical records to ensure proper documentation to support the authorization.
- There is a monthly reconciliation of the residential census against the actual authorization in ValueOptions' management information system by provider.

For **contracted providers** providing **child and adolescent residential and inpatient services**:
- There is a daily reconciliation of the inpatient census with the authorizations in the management information system.
- There is a monthly reconciliation of the residential census with the authorizations in the management information system.
- A biannual on-site audit is conducted to verify documentation of clinical need for Level I care against the certification of need and recertification of need in a person's record.

For **contracted providers** providing **outpatient services to adults and children**:
- On-site chart audits of persons in care more than 120 days from intake are conducted to evaluate the appropriateness of care for the person.
- On-site chart audits of cases closed less than 30 days from admission are conducted to ensure appropriateness of closure and use of outreach and engagement strategies.
- The Fraud and Abuse Department conducts data validation audits.

For **contracted pharmacies**, claims are received electronically immediately when a prescription is filled at the pharmacy. Because there is no time lag, all pharmacy QM and UM reports are based on paid claims.
- There is a weekly manual check of the claims report to ensure claims data is valid.
- ValueOptions maintains a closed doctor file, closed formulary file and closed pharmacy network file in the claims processing system, meaning it is impossible for claims to be paid to doctors or pharmacies not contracted or for medicines not on the formulary without a prior authorization in the claims system. This eliminates the possibility of inaccuracies in those areas.
- The online download of the electronic eligibility files to the Pharmacy Department implemented November 2001 eliminated the possibility of errors in entering eligibility data manually that could have an impact on UM data.

ValueOptions Direct Service Sites

To ensure complete, timely, and accurate data from direct service providers, ValueOptions implemented the following activities:

- For information submitted electronically by the ValueOptions Direct Service Sites, ValueOptions' Information Systems Department implemented a data "scrubber" that reviews QM data for completeness and accuracy and sends back error files with explanations to the sites to correct errors and resubmit the data. The process for direct service sites and contract providers is the same.
- For other QM or UM data that is entered by the direct service sites, Quality Management staff work with supervisors responsible for staff who enter the data and with staff from the ValueOptions IS/IT Department to develop production reports that managers use as a tool to measure staff performance, to require staff to fix errors in the report, and to improve timeliness.

RBHA Staff

Production reports are developed in collaboration with staff from Quality Management, IT/IS, and the managers of staff who enter the data. Managers use the production reports to measure staff performance, identify errors that staff are required to fix, and to improve timeliness. The Clinical Operations/UM Department uses the following reports to monitor and manage the validity of data:

- Daily Authorization Activity Report,
- Service Authorization Activity Report,
- Service Authorization Error Report,
- Review Date Report (Authorizations Reported the Previous Day),

- Review Due Report (Authorizations that Expire Tomorrow), and
- Case Load Scrub Report.

For **RBHA staff** entering UM data on **adult acute levels of care**:
- Care Management conducts verification of the existence of actual Certification of Need and Recertification of Need (CON/RON) to support 100% compliance on the Quarterly Showing Report.
- ValueOptions' Clinical Supervisors audit the Care Managers' clinical documentation and authorizations to review for accuracy and adherence to the Clinical Care Criteria.

For **RBHA staff** entering UM data on **adult residential services**:
- The Director of Clinical Services conducts audits of service denials to ensure proper documentation of the denials in the management information system.
- Supervisors conduct audits of the Care Manger's clinical documentation for each authorization to review for accuracy and adherence to Clinical Care Criteria.

For **RBHA staff** entering UM data on **child and adolescent residential and inpatient services**:
- The Director of Clinical Services conducts monthly audits of denials to ensure accuracy of documentation and application of Clinical Care Criteria.
- The Clinical Supervisor conducts monthly audits of Care Manger's clinical documentation of authorization to review for accuracy and adherence to Clinical Care Criteria.

Reports
Information systems production reports about the completeness, timeliness, and accuracy of data; results of monitoring activities of UM data; QM department logs of timeliness; and error file reports from contracted providers are forwarded to the QM Department where they are analyzed. Information is sent to the QM/UM Committee, which makes decisions about opportunities for improvement in the complete, timely, and accurate submission of data and instructs the Population-specific Management Committees to implement actions for improvement and report results. Examples of production reports used to manage and monitor the validity of UM data are:

- daily authorization activity report,
- service authorization error report,
- review date report (authorizations expired the previous day),
- review due (authorizations that expire tomorrow), and
- caseload scrub report.

Actions
The QM/UM Committee may mandate formal performance improvement activities. These may focus on how work processes can be improved to remove barriers to submission of complete, timely, and accurate data for RBHA staff. Outliers that are consistently making the same type of errors, identified through auditing and Information Systems production reports, receive **focused retraining**. A manager can also initiate this retraining without formal QM/UM Committee involvement. Contractors that continue to have large numbers of error files may be sanctioned by the Network Management Department and ValueOptions employees may be subjected to Human Resources intervention.

a. 8. Process and Focus of Provider Monitoring and Performance Improvement Activities

Provider Monitoring and Performance Improvement Activities
As described in *Volume 4a.6* above, ValueOptions will revise its provider monitoring process to assure universal application to all service providers, whether they are subcontracted to or directly operated by the RBHA. The process will allow us to assess with consistent measurements and goals appropriate for each population the quality of care provided to all consumers.

Purpose of Provider Performance Monitoring
The purpose of provider performance monitoring is to know how the system is performing, to identify outliers, and to obtain results of performance improvement activities.

Focus of Provider Performance Monitoring
The Executive Management Team decides ValueOptions' provider performance monitoring focus after reviewing DBHS directives, contract requirements, strategic initiatives, and Advisory Committee recommendations that will include consumer, family provider, and stakeholder input. Contract providers and internal staff are also asked for their comments and suggestions. The Executive Management Team decides overall goals. The QM/UM Committee determines what specific provider-monitoring activities will be implemented, and what information the QM/UM committee needs to receive to ensure that improvement is occurring.

The focus of monitoring for the **provider system as a whole**, by population, is to ensure excellent quality of care, fidelity to the system philosophy, and adherence to requirements. QM staff facilitate external audits, including Independent Case Review and Court Monitor's Audit, and evaluate specific performance parameters. Data is collected in methods that allow ValueOptions to drill down to identify specific outlier providers if there are system performance problems, to ascertain opportunities for improvement and to make changes to improve the effectiveness of the delivery system. Performance monitors collected for the system as a whole include:

- service utilization patterns and trends,
- average length of stay,
- readmission rates,
- evidence of over- and under-dosing of medications,
- over and under utilization of services,
- case management involvement with consumers discharged from inpatient/residential services,
- involvement of case managers in discharge planning,
- provision of service following discharge from 24-hour care,
- rates of admission/readmission to higher levels of care for consumers in active treatment,
- consumer satisfaction findings,
- encounter submission rates and accuracy,
- enrollment and disenrollment, and
- demographic submissions.

ValueOptions monitors **individual providers** to provide feedback to specific providers about their performance; to track results of Performance Improvement Initiatives that involve specific providers; and as part of the drill-down to determine outliers if there are system performance problems. Performance monitors always reported by individual providers include:

- access to care,
- coordination of care with PCP,
- family involvement,
- cultural preferences,
- sufficiency of assessment and treatment planning,
- types and intensity of services provided – including case management,
- outreach and follow-up,
- oversight by assigned clinician, and
- consent for medication.

ValueOptions monitors **individual practitioners** through specific performance indicators and provides feedback to these practitioners. Pharmacy sends monthly reports to prescribers that show a comparison of their prescribing patterns in relation to other prescribers. Monitoring for over- and under-utilization of services is used to notify practitioners about how they compare with groups of peers. Lastly, individual practitioners are monitored by tracking results of Performance Improvement Initiatives targeted for specific practitioners.

Process for Monitoring and Performance Improvement
Activities that generate monitoring data include:

- ADHS/DBHS Independent Case Review—ValueOptions facilitates the review process by making available copied records;
- Audits conducted by the Office of the Court Monitor—ValueOptions supports audits by providing staff to perform audit under the direction of the Court Monitor;
- Reports from ValueOptions Provider Monitoring --- Quality Management Department performs desk audits, annual site visits, and ad hoc focused reviews. Clinical Operations field care managers monitor providers. Finance department does encounter validation audits. Networks monitors for access to care standards and network sufficiency and cultural competency.
- Reports from ValueOptions departments that are prepared and sent to the QM Department, such as census, average length of stay, complaints, mortality reviews, and many others; and
- Reports that are generated by the Information Systems Department, which are routine production reports including outlier providers by number of error files, incomplete, untimely, or inaccurate data submission.

Data Analysis
The QM Department receives provider monitoring from the above sources. The QM Department determines the validity of the data, analyzes it using statistical methods and quality improvement technologies including trending, outlier identification, statistical process control charts, and others, and reports meaningful information about the results of provider monitoring to the QM/UM Committee.

Provider or practitioner-specific data used primarily to give regular feedback about performance is sent directly to the appropriate provider or practitioner for action. While these reports are trended by the QM department and reported to the QM/UM committee, it is expected that providers use these reports to identify outliers or practitioners that are not practicing consistent with the principles espoused by DBHS and take appropriate performance improvement actions. Providers' constructive use of these reports is evaluated through the provider monitoring process of the QM department and is reported to the Networks Department for contracted providers, the VP of Programs/Direct Services for direct services providers, and the QM/UM committee. Provider or practitioner specific monitoring data is combined with other provider or practitioner specific data and used by the Credentialing Committee for recredentialing.

QM/UM Committee
The QM/UM Committee receives information about results of provider monitoring and reviews it in light of policy, strategic initiatives, the QM/UM Plan, and other information provided through staff, consumers, families, and other stakeholders. The QM/UM Committee decides if performance improvement activities are needed, the area of focus for performance improvement activities, and what results will be expected and assigns the appropriate Population-specific Management Committee(s) to design and implement a Performance Improvement Activity (PIA) and achieve the desired result. QM Department staff will facilitate performance improvement teams.

Population-specific Management Committees—the SMI Committee, the General Mental Health and Substance Abuse Committee, and the Children's Committee—are responsible for designing the PIA and achieving the results required by the QM/UM Committee. These Committees are chaired by the Chief Clinical Officer and include among others the VP of Network Management and Program Development, VP of Programs/Direct Services, and the VP of Clinical Operations, all of which report to the Chief Clinical Officer operationally. Therefore any provider is either an employee of a member of the committee or is contractually obligated to a member of the committee. These Committees report results to the QM/UM Committee through the QM Department. These are operational management committees that are empowered and expected to achieve results.

The RBHA is the one agency that has responsibility for the coordination of services to persons with a serious mental illness. Information about the performance of direct service sites is provided to the QM/UM committee, as it is for contract

providers. The QM/UM Committee assesses the information it receives about meeting requirements, opportunities for improvement, and other quality indicators. Upon completion of the review process, they direct the SMI Population-specific Management Committee to develop a plan to address the identified issues.

One resolution may include the development of a performance improvement team. Other resolutions may include additional training, technical assistance, or Human Resource Department involvement. The SMI Population-specific Management Committee is chaired by the Chief Clinical Officer (CCO) and includes the VP of Network Management and Program Development, VP of Clinical Programs/Direct Services, VP of Clinical Operations, and Housing Placement Manager, as well as the Chief Medical Officer, Chief Administrative Officer, Chief Financial Officer, VP of Quality Management, Executive Director of Pharmacy, Director of Training, Chief Technology Officer, and other staff working with this population as needed. All staff concerned in issues with the SMI population are operationally coordinating management and performance improvement for consumers with a Serious Mental Illness.

In the ValueOptions QM/UM model, this Committee is given responsibility to implement targeted performance improvement activities and report progress back to the QM/UM committee. This process ensures coordination. For example, assume the QM/UM committee instructs the SMI Population-specific Management Committee to implement a performance improvement activity to achieve the exit stipulation requirements for discharges from supervisory care homes. All the departments of the RBHA that are involved with this issue are on the committee. The performance improvement team might include ValueOptions staff from direct service sites who serve this population, residential treatment and wraparound services providers brought in by the networks department, Housing Unit staff who find housing options for this population who work for the housing manager, consumers who have been involved in the program, and utilization management staff from the Clinical Operations Department who have to prioritize resources. This performance improvement team would receive information and facilitation services from the QM Department Performance Improvement Team. The SMI Population-specific Management Committee is responsible for ensuring that the performance improvement team achieves the desired results, and reporting those results and any new recommendations or suggestions for change to the QM/UM committee.

a. 9. Utilization Management Function and Structure

Scope and Goals of Utilization Management

The clinical philosophy of ValueOptions is to provide a system of managing care that offers easy access to the most appropriate, high quality mental health and substance abuse services for consumers and that supports providers in delivering clinically necessary and effective care with minimal administrative barriers. In addition, this philosophy assures that resources are used consistent with DBHS principles.

Situations that are not consistent with the *Arizona Children's Vision and Principles* and *Principles for Persons with a Serious Mental Illness* may be referred for specialized reviews. These specialized reviews may include evaluation for intensive care management, clinical rounds, Peer Advisor review, or more frequent care manager review. This is an example of using utilization management in a consultation role to help achieve a strategic initiative.

ValueOptions also believes in macro-management, to the extent possible, through the use of objective, standardized clinical protocols and outlier management programs. Prior authorization and concurrent review is reserved for high-cost, highly restrictive levels of service and for situations that represent clinical complexity and risk or where strategic agendas are being implemented to change practice patterns to be more aligned with DBHS principles.

When prior-authorization is required, Care Managers base their prior-authorization and concurrent stay reviews on clear and concise Clinical Care Criteria developed and pre-approved by DBHS specifically to guide level of service, treatment, and length of stay determinations. Care Managers are trained to match the intensity and severity of consumer needs in the clinical data presented to the covered services matrix with the goal of quality treatment in the least restrictive environment.

ValueOptions has designed a system of care that is based on principles of quality care and flexibility to meet the needs of consumers, diverse populations, and communities. The ValueOptions' system:

- provides easy and early access to appropriate treatment,
- works collaboratively with providers in delivering quality care according to accepted best-practice standards,
- addresses the needs of special populations, such as children, the elderly, and consumers who are seriously mentally ill,
- targets high risk cases for intensive care management, and
- emphasizes prevention, education, outreach, and recovery.

Organizational Structure and Staff Accountability

ValueOptions places a high value on the selection, training, and performance of clinical staff performing utilization management services. All staff members involved in utilization management activities must possess licensure/certification in their field. ValueOptions' Physician Peer Advisors and Medical Directors are experienced, board certified, or senior clinicians in their specialty areas.

The clinical utilization personnel are multidisciplinary and manage all general psychiatric, psychiatric subspecialty, and substance abuse services. ValueOptions requires that all Care Managers/Access Line Clinicians and reviewers hold licensure/certification as mental health professionals with prior clinical experience in a mental health/substance abuse setting providing direct patient care.

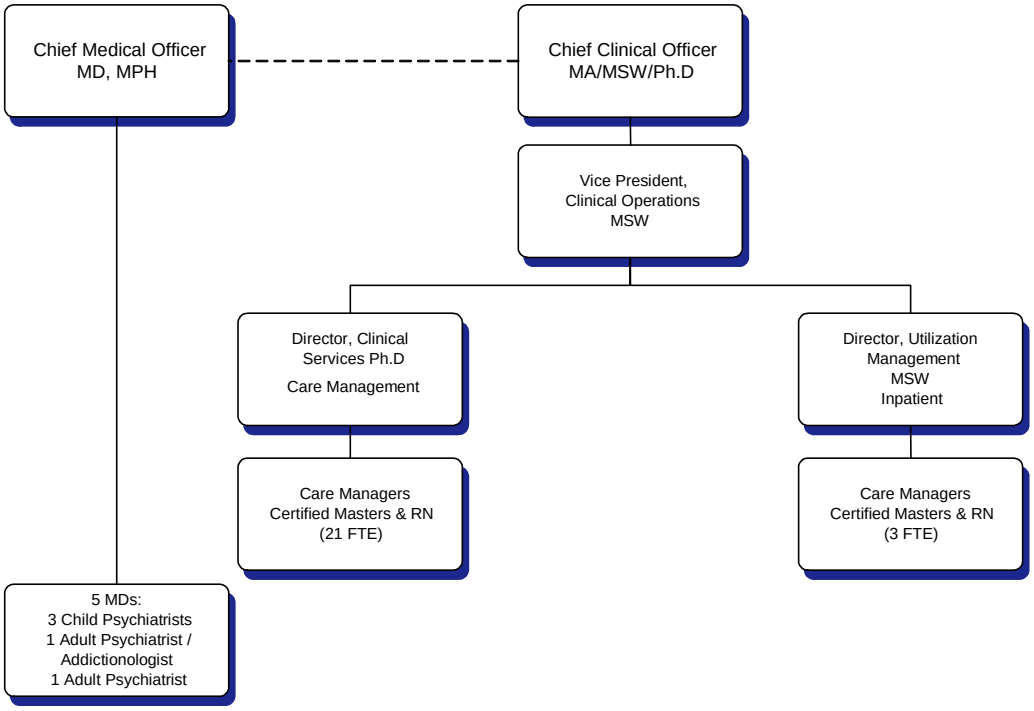
First-level review staff members are licensed nurses, licensed psychologists, and/or professional counselors, or Social Workers. These reviewers complete all types of reviews, including prior authorization, concurrent review, retrospective review, discharge planning, and care management. The staff available for clinical consultation are board certified or senior clinicians in the areas of psychiatry or psychology. Only a psychiatrist may make a decision to deny a requested authorization. The ValueOptions Human Resources Department maintains the status of current licensure for all actively employed clinical staff.

Utilization Management Personnel

The structure and personnel of the Utilization Management team is depicted in the organizational chart that follows.

Figure 4a(9).1

VALUEOPTIONS PHOENIX SERVICE CENTER
UTILIZATION MANAGEMENT TEAM



Systematic Process for Conducting Utilization Management Activities

The UM process assures that appropriate care that is prior authorized according to Clinical Care Criteria is delivered to consumers in the context of an individualized treatment plan, and in the least restrictive and most efficient manner. Care Managers consult collaboratively with providers, Primary Care Physicians, Clinical Team, Child and Family Team members, and Utilization Management personnel, as appropriate, to obtain relevant clinical information about the consumer's clinical status, treatment plans, treatment goals, and response to interventions. Care Managers enter clinical data relating to the need for a requested type of service and treatment planning considerations specific to these needs into ValueOptions' management information system.

Prior Authorization

Most behavioral health services do not require prior authorization. Prior authorization seeks to ensure that persons are treated in the most appropriate, least restrictive, and most cost effective setting, with sufficient intensity of service and supervision to safely and adequately treat the person's behavioral health condition.

ValueOptions uses the prior authorization review process, with DBHS prior approval, to ensure that services are used in the most effective and efficient manner to achieve the long term goals of DBHS as described in the *Arizona Vision and Principles for Children and Families* and the *Principles for Serving Persons with Serious Mental Illness*, as well as to provide consulting opportunities to assist providers with these principles and to reinforce the recovery philosophy. Behavioral health services requiring prior authorization include:

- extended inpatient hospitalization – Arizona State Hospital (OBHL Level I);
- acute inpatient hospital (OBHL Level I);
- crisis stabilization unit (OBHL Level I) – (no prior needed; authorization for continued stay);
- alternative care beds (OBHL Level I) – (no prior needed; authorization for continued stay);
- child/adolescent secure residential (OBHL Level I);
- child/adolescent residential (OBHL Level I);
- child/adolescent therapeutic group home (OBHL Level II);
- child/adolescent therapeutic group home (OBHL Level III);

- therapeutic (or treatment) foster homes;
- independent living skills assessment center (RRC) (OBHL Level II);
- adult basic residential (OBHL Level II);
- semi-supervised independent living – 16-hour SIL;
- partial hospital (behavioral health day programs);
- co-occurring disorders residential (OBHL Level II);
- provider affiliated housing;
- specific pharmacy practices;
- psychological and neurological testing; and
- electro-convulsive therapy.

Emergencies
Prior authorization is never required in an emergency situation. A retrospective review may be conducted after the person's immediate behavioral health needs have been met to ensure appropriate treatment of the behavioral health emergency. If upon review of the circumstances, the behavioral health services did not meet admission authorization criteria, payment for the service may be denied.

Outpatient Requests
ValueOptions does not require authorization for outpatient services provided by a contract provider with the exception of psychological and neurological testing, specific pharmacy practices, partial hospital (behavioral health day program), and electro-convulsive therapy.

Timelines for Making Prior Authorization Decisions
Prior authorization decisions must occur within the following timeframes:

Service	Timeframe
Psychiatric acute hospital or sub-acute facility	1 hour
Residential treatment center for persons under the age of 21	24 hours
Therapeutic foster care	5 business days
Level II and Level III residential for adults	3 business days
Semi-supervised independent living – 16 hour SIL	3 business days
Provider-affiliated housing	3 business days
Specialized testing/psychological testing	1 business day
Request for medication	24 hours
Electro-convulsive therapy	1 business day

Requests for Continued Stay
Requests for continued stay must be scheduled with the reviewing care manager by the last day of the authorization. Failure to do so will result in the case being placed in administrative denial status until the required clinical information is received. A provider may request a retrospective review for the denied services. Written notification of denials will be sent to the provider and consumer within 24 hours of the determination. Upon call back from the provider, a concurrent review will be conducted from the date of the call with the remaining time placed in administrative denial.

ValueOptions complies with federal utilization control requirements (CON, RON, Federal requirements for UM Plans, UM Committees, plan of care and medical care evaluation studies for hospital, mental hospital, RTC, and Sub-acute facilities as prescribed in 42 CFR parts 441 and 456).

Process for Assuring Compliance
The following four processes are in place to ensure that clinical administration continues to achieve its goal that 100% of all Certification of Need (CON) and Re-Certification of Need (RON) documents are in compliance with 42 CFR standards:

- All Level I admissions and continued stay reviews require certification.
- Only designated ValueOptions' clinical staff (appropriately credentialed Mental Health Professionals) can authorize Level I admission and continued stay.

- ValueOptions' management information system authorizations are not entered without appropriate clinical justification and the receipt of CON/RON documents that are in full compliance with 42 CFR.
- CON/RON documents are returned to providers with instructions on how to correct deficiencies.

All designated ValueOptions' clinical staff members receive initial and ongoing training relative to 42 CFR CON/RON requirements.

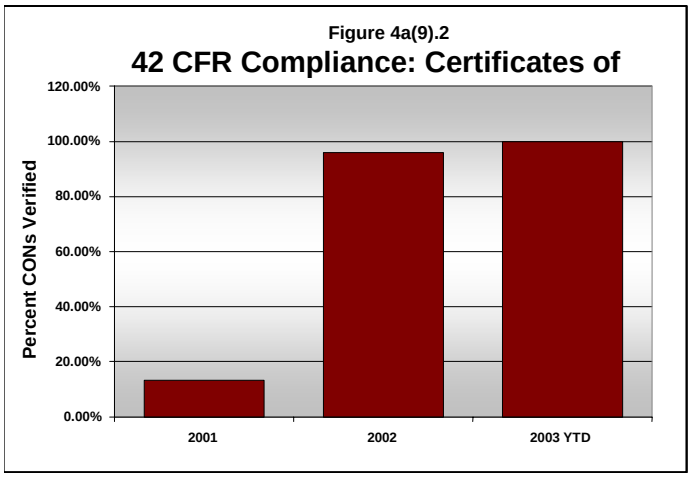
Executive Review of Performance
The Director of Clinical Services conducts an audit of a minimum of 10 percent of all submitted final CON/RON documents quarterly. The findings of quarterly audits are reported to the Medical Director and the Director of Clinical Administration. Audit results below 100 percent require an immediate corrective action plan.

Assessment of Performance
The fourth quarter 2001 CON/RON audit demonstrated a 13.3 percent 42 CFR compliance rating. Working with several Level I providers, it was determined the CON/RON format was cumbersome, misleading, and vague.

As a result of this collaboration, a series of new CON/RON documents were created, one specific to each covered Level I service (i.e., psychiatric hospitalization, crisis recovery unit, detoxification, and RTC). Once constructed, all ValueOptions and provider clinical staff members were trained in their use.

The results were dramatic. First and second quarter 2002 CON/RON audits resulted in 42 CFR compliance ratings of 96 percent. The most recent (first quarter 2003) CON/RON audit demonstrated a 100 percent compliance rating.

Figure 4a(9).2



Operational Plan
Our operational plan is to continue to require the presence of 42 CFR compliant CON/RON documents before entering any authorization into our system, review by the Clinical Lead, rejection of all CON/RON documents which fail to meet 42 CFR standards, quarterly audits by the Director of Clinical Services, reports directly to the Medical Director and Director of Clinical Administration, and immediate implementation of corrective actions in the event an audit produces results below 100 percent compliance.

Monitoring Activities for Compliance with 42 CFR
We will continue the current three-tiered monitoring process:

1. ValueOptions' clinical staff review,
2. Clinical Lead inspection, and
3. Director of Clinical Services audit.

ValueOptions has developed an authorization code that will allow tracking receipt of CON/RONs. This will make possible the daily reporting on cases for which ValueOptions has not received a CON/RON. These data can be analyzed to identify barriers, training needs to maximize compliance with this requirement, and give ValueOptions information regarding providers/practitioners who may need technical assistance regarding compliance with the 42 CFR requirements.

Current Performance
During the August 2003 Administrative Review, ValueOptions received a full compliance rating for this standard.

Training and Technical Assistance

Each designated ValueOptions clinical staff member receives initial and ongoing training (minimum of twice per year) relative to 42 CFR requirements. ValueOptions tests inter-rater reliability twice a year to ensure uniform application of the clinical care criteria and provides training with children's providers on clinical care criteria for out of home placement. Field care management identifies opportunities for improvement, provides technical assistance in treatment planning, application of clinical care criteria, discharge planning, and training on ASAM criteria for substance abuse treatment providers and SMI clinics.

a.10. Utilization Monitoring

Areas for which we Monitor Under- and Over-utilization

ValueOptions reviews under- and over-utilization in areas that are high risk, high volume, or of high strategic importance for implementing the recovery model for adults or the Arizona Practice Model for children. The latter is especially important since implementation of major practice initiatives involves significant change in the use of types of services. For example, implementing the Arizona Practice Model for children requires monitoring for under utilization of support services. Current areas of focus include:

- crisis services/inpatient (adults and children);
- adult residential services under Office of Behavioral Health Licensure (OBHL) Level II, and Level III for persons with a serious mental illness;
- OBHL Level I, II, and III residential services for children and adolescents;
- court-ordered services for adults;
- mortality reviews;
- pharmacy;
- outpatient services for adults and children;

To ensure effective and comprehensive monitoring, detection, and correction of potential under- and over-utilization of services, ValueOptions implemented a three-tiered approach:

1. Corporate staff members review utilization data from multiple sites across ValueOptions' public sector division, including the Maricopa County RBHA, for comparison purposes and to facilitate knowledge exchange. Instances of rates significantly lower or higher than the standard utilization are subject to further analysis.
2. The RBHA reports daily utilization data detailing units of service for each of the out-of-home levels of care (e.g., inpatient, residential, partial day, group home, and others). These data are evaluated by the Clinical Operations Department for utilization trends and patterns of under- and over-utilization. They are evaluated in terms of the budgeted utilization forecast based upon past utilization and enrollment. The Quality Management Department analyzes these utilization data and sends the analysis to the QM/UM Committee, which will review in light of the current areas of focus and instruct Population Specific Management Committee(s) in order to implement corrective action plans to respond to patterns of under- or over-utilization.
3. Annually, the Director of Utilization Management provides an analysis of performance compared to goals, including the achievement of strategic initiatives such as correcting underutilization of the support services needed to implement the Arizona Model. This analysis includes systemic deficiencies and/or barriers that contributed to the discrepancies, what was done to correct them, and the results achieved; feedback from the DBHS Administrative Review; and areas in which discrepancies still exist or areas in which goals should be changed. The Chief Medical Officer and the QM/UM Committee approve the analysis in December before submission to the Executive Management Team in January. The analysis includes review of UM information, anticipated influx of high risk or high volume populations, strategic initiatives, and stakeholder input. Based on Executive Management Team response, the Director of Utilization Management prepares an action plan for the next year, including major initiatives to be implemented, anticipated impact, with person will be responsible for implementation, and timelines for completion. The Chief Medical Officer and QM/UM Committee approve this plan in January before submission to the Executive Management Team in February. The Executive Management Team ultimately approves the QM/UM Plan

Monitoring Activities

The Director of UM publishes a daily list of "Ready for Discharge" adult consumers in all Level I facilities and communicates this information to all Direct Service SMI Clinics. In addition to the daily Discharge Ready List, Care Managers meet daily with Level I adult providers in medical rounds to review for continued stay Clinical Care Criteria.

A weekly Discharge Planning call is held to review all consumers admitted into inpatient care by ValueOptions Direct Service Site Staff. Most adult inpatient admissions are case managed through a Direct Services Site. ValueOptions requires that all parties attend the call to discuss specific consumer needs that must be met to assure a successful discharge, such as appropriate discharge planning, identification of precipitating factors and early warning signs, current treatment, coordination of care, community services needed, special needs, existing and needed supports, barriers to discharge, and strategies to

remove the identified barriers. For Level I children continued stay is reviewed by a combination of telephonic and on site review.

The RBHA provides oversight in monitoring for under- and over-utilization through the Residential Application Screening process conducted daily by the Residential Coordinator, the Medical Director (or designee), and Clinical Supervisor and through analysis of length of stay data. Care Managers provide concurrent review and onsite retrospective review against clinical care criteria. If criteria are not met, Care Managers collaborate with the providers to explore appropriate treatment alternatives. Only the Medical Director (or physician designee) can do a denial, which is rarely necessary.

Pharmacy monitors are aligned with the monitors of the ADHS Administrative Review and are compiled and reviewed quarterly. The prior authorization process in pharmacy is used as a consultation opportunity for over and under utilization of pharmacy services and for underutilization of treatment, support, or rehabilitation services.

Using the coding structure within ValueOptions' management information system, we program authorization codes that will enable our staff to track the number of days authorized at a higher service level because a clinically appropriate lower service level is not available or because the consumer is in hospital due to court ordered evaluation.

ValueOptions monitors over utilization of services for Title XIX and Title XXI behavioral health recipients aged 21 to 64 years in an Institution for Mental Disease according to ADHS/DBHS service limitations (not to exceed 30 days per admission or 60 days per contract year) through tracking all IMD admissions. When consumers get close to either the 30- or 60-day limit, we discuss movement to a non-IMD with the facility. The Clinical Supervisor audits the process monthly.

ValueOptions monitors the over-utilization of respite services to Title XIX and Title XXI behavioral health recipients according to ADHS/DBHS service limitations (not to exceed 720 hours per contract year) through the Clinical Liaison of the responsible provider. The Clinical Liaison monitors and reports to ValueOptions' Claims Department when a consumer's respite services reach 700 hours.

Indicators to Monitor Over- and Under-utilization
Listed below are the indicators currently used to monitor over-and under utilization.

Acute Levels of Care
- level One adult acute inpatient re-admissions within 30 days;
- inpatient disposition summary;
- average number of case-managed Level One adult acute inpatient admissions per 1000 by Severely Mentally Ill (SMI) treatment clinic by month;
- average length of stay for Level One adult acute inpatient by month, per 1000;
- total percent of direct service clinics' enrollment admitted to Crisis Recovery Units (CRU) by month;
- average length of stay: adult CRU by month;
- adequacy of discharge treatment plans for consumers readmitted after 30 days; and
- contracted providers' submission of census information for every out-of-home level of service per day.

Adult Residential Services Monitoring
- adult residential applications approved as requested,
- adults with serious mental illness prematurely discharged from residential placement against the RBHA's advice,
- inter-rater reliability of decisions by Access Line Clinicians/Care Managers and Physician Advisors, and
- average length of stay in out-of-home placement.

Child and Adolescent Residential and Inpatient Services Monitoring
- percent of capacity being treated while living in out-of-home placements by month by CSP,
- percent of capacity inpatient by month by CSP,
- percent of capacity in Secure Residential Treatment Centers by month by CSP,
- percent of capacity in Residential Treatment Centers by month by CSP,
- percent of capacity in Therapeutic Group Homes by month by CSP,
- child and adolescent residential applications approved as requested, and
- inpatient readmissions within 30 days

Court-ordered Treatment Services Monitoring

- interventions received by persons on court-ordered treatment status who are living in Maricopa County and are non-adherent to their treatment plan, and
- implementation of special treatment plan when treatment no-adherence occurs

Confirmed Instances of Under- and Over-utilization Identified through Mortality Reviews

Mortality reviews which result in confirmed instances of under- and over utilization of services.

Pharmacy Services

- the provision of education and information regarding the ValueOptions' pharmacy system and enrollee benefit;
- the provision of continuing medical education addressing efficient and effective pharmacy practice;
- the peer review of outlier consumers with pharmacy costs exceeding $1000 per month for efficient and effective pharmacy practice and identification of inappropriate polypharmacy;
- the peer review of prescribers with pharmacy prescribing patterns exceeding the amount greater than one standard deviation above the group norm;
- the review of evidence-based pharmacy practices to enhance prescriber awareness of specific prescribing concerns – use of two medications in same class, potentially under or over dosage of an atypical antipsychotic, non-adherence to medication, children receiving greater than three psychotropic medications, and adults receiving greater than four, sedative or hypnotic use for greater than 60 days, consumers with multiple prescribers; and
- the impact of the drug utilization review process – prior authorizations – reviewing medication use or dose appropriateness, time appropriateness of dose increases, duplicate therapies within the same class, polypharmacy – with emphasis on educating prescribers on best practice guidelines, evidence-based practices, and cost sensitivity.

Outpatient Monitoring Adults and Children

ValueOptions monitors under utilization of outpatient services including case management though the efforts of its field care management unit. Field Care Managers identify all cases closed within 30 days of admit and review 10 percent of those cases using an audit tool jointly developed with quality management and network management staff based on ADHS/DBHS independent case review tool. Care Managers review for appropriateness of closure, and adequacy of out reach and follow-up.

Over utilization is monitored by identifying all cases in care over 120 days. Field Care Mangers monitor services delivered, including case management, using the audit tool described above. They are monitoring for need for current treatment, adequacy of care, evidence of active treatment planning, and inclusion of family, cultural appropriateness of the treatment intervention, and whether the level of service addresses the clinical need of the consumer/family.

Field Care Managers address identified opportunities for improvement by providing onsite technical assistance utilizing an ICR Standard Attainment Lesson Plan jointly developed by Clinical Administration, Quality Management, and Network staff. This training module teaches the following areas including but not limited to: DBHS service planning and documentation techniques for Cultural Competency, PCP coordination, member and family involvement, access to care, clinical outcomes, pharmacy, and outreach and follow-up.

Monitoring and Analyzing Case Management

ValueOptions generates a quarterly report of encounters by provider by covered service category by fund type. This report summarizes number of units of service and dollars. Utilization management staff reviews this report for outlier providers compared to contract amounts of covered services. Contracts are block purchased based on expected utilization requirements by covered services category and fund type. The QM department will establish the thresholds for identifying outlier providers. The QM/UM Committee will establish areas of focus by covered service type, one of which will be case management services and/or covered services category. Clinician auditors from the Clinical Operations Department will read a quarterly sample of charts from outlier providers to determine if consumers are receiving the proper amount of a specific covered service or covered services category based on the consumer's assessment and service plan. Results of these audits will be reported quarterly to the QM department, which will ensure the validity of the data and convert it to meaningful information for review and action by the QM/UM Committee. This activity will be important for tracking the change in service mix with implementation of Child and Family Teams to more support services.

b.1. Notice Requirements

ValueOptions places great importance on notifying consumers of their appeal rights. In this section, we describe how we will meet the notice requirements as well as ensure compliance through policies, notice content, ongoing education, training, monitoring, and oversight. ValueOptions has already demonstrated success in this area. ValueOptions increased compliance for supplying notices from 85 percent in 2002 to 96 percent in 2003. This is one example that demonstrates ValueOptions commitment to providing timely, correct, and accessible notices.

Our procedures to ensure compliance include the following:

- All appeals forms for consumers are available in both English and Spanish.
- At the time of each consumer's enrollment, ValueOptions and/or its subcontracted providers provide an explanation of the appeal process.
- ValueOptions uses qualified interpreters to assist consumers as necessary.
- ValueOptions and/or its providers post the Notice of Client Rights and provide consumers enrolling for Seriously Mentally Ill (SMI) services with a copy.
- ValueOptions and/or its providers also supply the Notice at time of the consumer's discharge.

Specific Rights and Policies

Upon an action or event requiring notice to a consumer, ValueOptions and our contracted providers and direct service sites abide by all ADHS/DBHS policies and timeframes for disseminating notices. All notices are handed directly to the consumer in person or, if the consumer is not present at the time of the decision, the notices are sent by certified mail to the consumer.

For consumers in programs for Children and Adolescents, Substance Abuse, or General Mental Health, notices are handed to the consumer at the time of enrollment. Notices are mailed to consumers when a request for prior authorization of a service is denied or when prior authorized services are reduced, limited, suspended or terminated, including modifications of the type or level of service provided. Notices are mailed to consumers upon a failure to provide timely services; upon a denial, in whole or part, for payment of a service; or upon the failure to resolve an appeal or complaint to established parties, including failure to notify affected parties.

For persons applying for SMI eligibility, ValueOptions ensures that all applicants receive notice of the right to appeal their eligibility determination and are notified that they may access the State's fair hearing process. All notices are handed directly to the consumer in person or, if the consumer is not present at the time of any decisions made regarding SMI eligibility, the notices are sent by certified mail to the consumer. ValueOptions or its contracted providers or direct service sites sends notices by certified mail to consumers with a serious mental illness when a decision is made regarding fees and waivers; when an assessment report, individual service plan, treatment plan and a discharge plan is developed, provided or reviewed; when there is an outcome of a grievance or rights violation; when a decision is made to reduce, suspend, or terminate a service as part of the individual service plan that does not require prior authorization or is a service funded through Non-Title XIX funds; and when a decision is made that the person is no longer eligible for SMI services.

Content of Notices

ValueOptions and its participating providers supply timely notices to consumers or legal guardians and specify the reason for the decision and actions that are to be taken. Because ValueOptions understands the importance of accessible literature to enable consumers to obtain, process, and understand basic information on appeals, ValueOptions' notices are written in language that is easily understood and avoids clinical jargon. ValueOptions also includes information on how to access language assistance, including interpreter services, if appropriate. ValueOptions adheres to ADHS/DBHS timeframes for notice of intended actions. ValueOptions' notices inform consumers that staff members are available to assist with initiating the filing of an appeal. The ValueOptions Customer Service and Grievance and Appeal Departments consistently offer to and often assist consumers with this process. To ensure staff members are skilled in this area, the Grievance and Appeals Department facilitates internal appeals training twice every quarter.

The following information is included in the notices provided to persons determined to have a serious mental illness or persons applying for SMI services.

- the person's right to appeal and to an administrative hearing;
- the method by which an appeal and an administrative hearing may be obtained;
- that the person may represent himself/herself or use legal counsel or other appropriate representatives;
- the services available to assist the person from the Office of Human Rights, Human Rights Committees, Protection and Advocacy System and other peer and advocacy services;
- the reasons and intended action the notifying entity intends to take;

- the specific rules or laws that support the action; and
- an explanation of the circumstances under which services will continue if an appeal or an administrative hearing is requested.

In order to ensure that consumers are able to exercise their rights, ValueOptions takes the following actions:

Ongoing Education for Consumers

To ensure that consumers are adequately informed of their rights to voice complaints and request grievance procedures, ValueOptions educates them about grievance and appeals rights through the Member Information Handbook, Consumer Connection newsletter, new enrollee letter, as well through ongoing discussion and education of Peer Advocates, Access Line clinicians, and network providers.

Staff and Provider Training

ValueOptions Grievance and Appeals Department provides face-to-face training twice quarterly and technical assistance, both in person and by telephone, on an ongoing basis about notice requirements. These training sessions inform participants that the action to be taken and the appeal process available must be explained to the person or custodial/legal guardian and that the appropriate ADHS/DBHS notice must be provided for the specific type of service disposition within the required timeframes. Notice requirement training is facilitated by the Grievance and Appeals Manager quarterly (or more frequently as needed as determined by the Manager of Grievance and Appeals or by the QM/UM Committee) and is presented to employees, providers, consumers and their families. The trainings emphasize that notices need to be timely, in accordance with ADHS requirements; that the appropriate decision was cited; and that the explanations provided to the consumer are easily understood. In addition to training activities, the Grievance and Appeals Manager is available to providers and ValueOptions staff to answer technical questions regarding Notices. The Grievance and Appeals Manager also provides feedback to internal staff and providers when Notice errors are discovered through the monitoring process or through the processing of appeals. For internal staff, the Grievance and Appeals training module is part of New Hire Training, which occurs every two weeks. All newly hired ValueOptions employees are required to attend the training.

Monitoring the Sending and Tracking of Notices

ValueOptions hand delivers notices or sends notices via certified mail to ensure that consumers actually receive the notices. The ValueOptions Director of Clinical Services and the Executive Director of Pharmacy Services track all ValueOptions notices, and conduct monthly reviews of outgoing notices to ensure that complete and accurate notices are sent within ADHS/DBHS timeframes. The Director of Clinical Services and the Executive Director of Pharmacy create quarterly reports of findings. These reports are submitted to the Grievance and Appeals Manager to identify any patterns of error and needs for performance improvement.

Providers are involved with the request and review of the clinical decisions for each consumer. ValueOptions informs providers when decisions are denied, reduced, suspended, and/or terminated. To ensure that consumers receive notice of decisions made by the Clinical Operations and Pharmacy Services Departments, both departments will send copies of notices to the consumer's case management sites to give to consumers as well as sending them certified mail to the consumer.

Ongoing Improvement

The ValueOptions Grievance and Appeals Department is responsible for ensuring that notice requirements are met through the monitoring activities described above and by reviewing notices given to consumers by providers that result in the filing of appeals. The Grievance and Appeals Department resolves individual provider performance problems. Systemic patterns, trends and outliers are identified by the Quality Management Department through monthly Trending Analyses of Grievances and Appeals. These issues are then presented to the Quality Management/ Utilization Management Committee for review and possible assignment of performance improvement activities.

b.2. Grievance and Appeals Function

All consumers, family members or legal guardians contacting ValueOptions or its subcontracted providers with a behavioral health services complaint are encouraged to resolve concerns at the lowest level possible. ValueOptions continually educates consumers, family members and legal guardians of their right to appeal or file a grievance. Consumers are informed of the steps to file a formal complaint and of the appeal process. The Customer Service and Grievance and Appeal Departments consistently offer assistance to consumers for informal problem resolutions and filing a complaint or appeal.

The function of ValueOptions Grievance and Appeals Department is to facilitate resolution of grievances and/or appeals competently, expeditiously and equitably. In addressing the combination of increased enrollment and more informed consumers, ValueOptions has seen a higher volume of requests. This department has grown by three additional staff since 1999.

The Grievance and Appeals Department facilitates to resolution the process of all filed consumer grievances, consumer appeals, and provider appeals in accordance with all applicable state and federal laws. The Grievance and Appeals Department enters grievance, appeals and requests for hearing information into the ADHS/DBHS Office of Grievance and Appeals database (OGA database) in accordance with the Office of Grievance and Appeals Database Manual. Initial and updated entries also are made into the OGA database within three (3) days of an event requiring entry.

The Grievance and Appeals Manager is also responsible for educating persons about their rights and the process for filing complaints and appeals by meeting directly with consumers at provider facilities, drop-in centers, and ValueOptions' training center. The Grievance and Appeals Manager provides training to providers, other departments and consumers on the grievance and appeals process twice quarterly. The Grievance and Appeals Process is included in New Employee Orientation. The ValueOptions training module highlights notice provision requirements, types of decisions or actions that can be appealed, types of issues that can be appealed, method to file the appeal, the step by step of the appeal process and consumer's rights in the process. The training also covers the grievance process including types of rights violations, formal investigation process and informal steps to resolve concerns.

The Grievance and Appeals Department tracks grievances and appeals to identify potential deficiencies in the delivery system. The Grievance and Appeals Operations Manager coordinates with the Network Management Department to resolve identified performance problems with individual providers. Systemic patterns, trends and outliers are identified by the Quality Management Department through monthly Trending Analyses of Grievances and Appeals. These issues are then presented to the Quality Management and Utilization Management Committee for development of performance improvement initiatives.

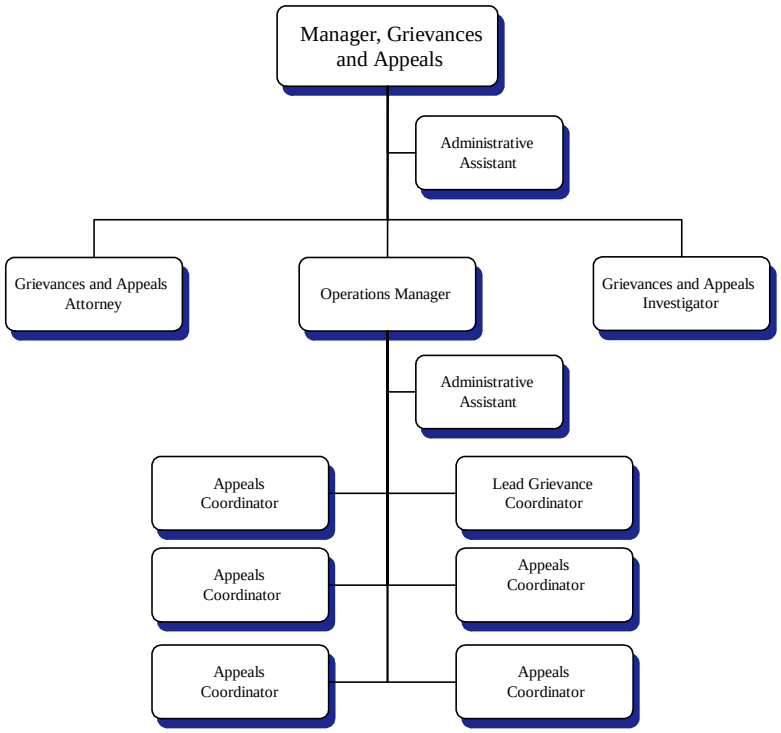
To accommodate the new ADHS requirements for Grievance and Appeals, the increase in the requests we receive, and the requirements of the Balanced Budget Act regarding the appeals process, ValueOptions is in the process of reorganizing the Grievance and Appeals Department. The Grievance and Appeals Department will consist of the following positions:

Staff	FTE	Responsibilities/Qualifications
Manager	1	Oversees and ensures appropriate processing of grievances, appeals, provider appeals and requests for State Hearing, and provides direct supervision to the Grievance and Appeals Attorney, Operations Manager and the Investigator. Responsible for conclusions of formal investigations and decision letters, and directly facilitates provider appeals upon department's receipt. This position must have a legal background, which will either be a licensed attorney, law degree or certified Arizona Paralegal.
Attorney	1	Represents ValueOptions in all grievance/appeal matters that have been forwarded to the Fair Hearing level at the Office of Administrative Hearings. An attorney staffs this position with an Arizona State Bar License in good standing.
Operations Manager	1	Responsible for direct supervision of the Lead Grievance Coordinator, Appeals Coordinators and an Administrative Assistant. Reviews incoming treatment appeals and ensures appropriate processing of cases received. Facilitates possible resolution of cases and/or assigns appeals to Grievance and Appeals Coordinators. The Operations Manger must have a minimum of a Bachelor's degree in behavioral health or social services and a minimum of five years in the health care related industry, with one year of quality management experience preferred.

Staff	FTE	Responsibilities/Qualifications
Lead Grievance Coordinator	1	Reviews grievances received in an effort to identify possible consumer rights violations in accordance with A.A.C. R9-21, Articles 2 & 3. Reviews include interviewing filing party and all appropriate agency employees. Witnesses and reviews all available documentation. Drafts acknowledgement/decision letters and corresponds with filing parties. Facilitates formal grievance investigations when Investigator has high volume of assigned cases. This position must have a minimum of a Bachelor's degree in behavioral health or social services and experience of three years in the health care related industry, with one year of quality management experience preferred.
Investigator	1	Facilitates formal investigation process of grievances filed in which a factual dispute exists and a possible rights violation has been identified. Interviews grievant and all appropriate witnesses and personnel. Reviews all appropriate documentation and consults with company professionals involving clinical and legal matters. This position must have a Bachelor's degree; with three years experience in the behavioral health field preferred. Investigation Certification is preferred.
Appeals Coordinator	5	Coordinates scheduling of informal appeals conferences for SMI eligibility and treatment appeal cases assigned. Acts as advocate in cases where the consumer is unrepresented and strives to facilitate resolution. Share informal conference mediation role in cases not directly assigned to them. This position must have a Bachelor's degree in behavioral health or social services and experience of three years in the health care related industry, with one year of QM/UM experience preferred.
Administrative Assistant	2	Facilitates clerical functions of department including, but not limited to, entry of data into OGA Database and Department's internal database, assignment of docket numbers to incoming grievances and appeals, maintaining organization of closed files, maintaining of Attorney's court hearing calendar and processing of outgoing correspondence. This position must have a minimum degree qualification of a high school diploma or GED and a minimum two years of clerical experience.

We provide an organizational chart of the reorganized Grievance and Appeals Department below.

VALUEOPTIONS
GRIEVANCES AND APPEALS DEPARTMENT



b.3. Grievance and Appeals Process

ValueOptions complies with state and federal law as it relates to consumer and provider grievances and appeals. ValueOptions' objective for the complaint and appeal process is to ensure that we:

- informally resolve disputes, complaints, and appeals as quickly and fairly as possible;
- establish an environment where consumers feel comfortable conveying their needs and are treated with dignity and respect;
- maintain confidentiality and privacy of the complaints/appeals matters and records at all times;
- communicate, appropriate, timely information on matters and decisions related to the complaint/appeal to affected parties;
- involve the active cooperation and participation of providers with a direct interest in the matter under review;
- provide education and training to ValueOptions and provider staff regarding consumer rights and the complaint/appeal process; and
- track the types of complaints/appeals to identify potential deficiencies in the delivery system for which corrective action plans can be developed.

Consumer complaints are handled through several processes. What process is used is dependent on eligibility and enrollment status and certain choices available to the consumer. These processes include; informal dispute resolution, the formal appeals process that includes informal conferences and a hearing before an administrative law judge if the issue is not resolved; and expedited appeals for certain cases.

Informal Dispute Resolution

Throughout the consumer complaint process, all staff involved strive to facilitate informal resolution. ValueOptions' Customer Service Department is usually the first point of contact for consumer complaints. The Customer Service Department addresses consumer complaints in a prompt and informal manner. Despite the efforts to facilitate informal dispute resolution, the consumer always has the choice and right to request to utilize the formal Grievance and Appeals Process. The Customer Service Department has established a practice of advising the consumer of the option to formally resolve issues by using the Grievance and Appeals Process. This practice allows the consumer to have all of the information necessary to choose the best option for resolution. Customer Service staff and clinic staff give the consumer the option to relay oral information on the telephone or in person. That information is then transferred to the "ADHS/DBHS Complaint Form" by ValueOptions' Customer Service staff. The form is then immediately forwarded to the Grievance and Appeals Department either by interoffice mail or by facsimile. Throughout all levels of the formal appeals process, the Grievance and Appeals Department staff seek informal dispute resolution.

Handling of Complaints of Consumers with a Serious Mental Illness (SMI) Non-Title XIX

Customer Services is available to handle all consumer complaints when received by telephone or in writing. If a consumer requests an appeal or if a ValueOptions Customer Service Representative identifies the complaint involves an appealable issue or a potential rights violation, the representative forwards the complaint in writing to the Grievance and Appeals Department. Consumers with a Serious Mental Illness have the right to formally appeal denials, terminations, suspensions, reductions in any service, to grieve consumer rights violations, SMI eligibility and any individual service plan change. A person may request an expedited appeal on issues related to crisis or emergency services or for good cause. The complaint/appeal is then formally docketed and categorized according to ADHS/DBHS requirements. The ValueOptions Grievance and Appeals Operational Manager reviews the form to determine how best to facilitate an immediate informal resolution prior to initiating the formal process. An informal resolution may include addressing cultural issues that may be interfering with the treatment process or exploring options with direct care staff by utilizing designated clinical advisors. The objective is to ensure that all information is gathered that is necessary to recommend a resolution, which may include obtaining medical records from in state and out-of-state mental health providers, interviewing ValueOptions and subcontracted provider staff, and reviewing applicable policies and protocols. For consumers who do not speak English, staff members will immediately seek the necessary translation services for communications with consumers. In addition correspondence to the consumer who does not speak English will be translated into their primary language.

If a consumer chooses or if a case is designated for the RBHA Appeals Process, the Grievance and Appeals file is then forwarded to a Grievance and Appeals Coordinator. The Coordinator is a customer service advocate for the consumer. The

Coordinator guides the consumer through the appeals process and ensures the consumer is given reasonable opportunity to present evidence and allegations of fact or law in person and in writing. The Coordinator is readily available to answer the consumer's questions concerning the ValueOptions' system and the Grievance and Appeals process. The Coordinator gathers information necessary to resolve the case, and may also investigate facts surrounding the case. The data gathered during the investigation is used to reach an informal resolution and to ensure that all the necessary information is available for the parties during the Informal Conference.

RBHA Informal Conference
In accordance with DBHS Policy requirements, the RBHA appeals process includes an Informal Conference with the parties involved. The informal conference is designed to gather information and to seek possible resolution. The Grievance and Appeals Department has a designated conference room to conduct Informal Conferences. Consumer privacy is enhanced by the location of the conference room in a non-public area.

When indicated, the Coordinators are also available to arrange for informal conferences to take place off-site. For example, informal conferences are facilitated at local jails, at other ValueOptions' sites and at Arizona State Hospital. The Coordinators also collaborate with the ValueOptions Access Line Staff to facilitate transportation for Title XIX/XXI consumers who need these services to attend their Informal Conference.

In the event that there is a language barrier, ValueOptions has access to several subcontracted interpreter services, which are available when necessary to allow greater understanding for consumers of the process. Currently there is one Grievance and Appeals staff member available for Spanish translation but other personnel within ValueOptions, e.g., Customer Service Representatives, are also available to assist with Spanish speaking consumers.

The consumer and the consumer's family or advocates may attend the informal conference telephonically using a speaker telephone if they cannot or choose not to attend in person. The consumer may have family members or advocates attend the conference. Every effort is made to schedule the conference at a convenient time for the consumer and anyone else attending on the consumer's behalf. As indicated above, interpreter services are made available as necessary.

The Informal Conferences are designed to address problem resolution in an open and accepting environment. A Grievance and Appeals Coordinator not assigned to the case as the Advocate/Coordinator mediates the conferences. Prior to the beginning of the conference regarding SMI eligibility, the Grievance and Appeals Coordinator explains to the consumer what will happen at the conference, as well as explaining the consumer's benefits available via Title XIX/XXI benefits. When the conference convenes, a ValueOptions Eligibility Representative also attends. We use the ValueOptions' Mediation Form as a guide to ensure that no essential steps to the process are overlooked, all of the necessary information is being gathered, and a plan of action is included so that all parties know how the process will proceed after the conference.

The appeals process ensures that individuals who make decisions regarding appeals are not involved in any previous level of review or decision-making. The individuals must be health care professionals, as defined by the ADHS/DBHS Provider Manual, with the appropriate clinical expertise in treating the behavioral health consumer's behavioral health condition when making a decision regarding an appeal related to the denial of expedited resolution of an appeal or complaints involving clinical issues.

ADHS/DBHS Informal Conference
Consumers who have already been determined to have a serious mental illness are given the option to proceed to the second informal conference level with ADHS/DBHS should acceptable resolution not be attained at the first informal conference. If the consumer chooses to utilize this level, the Grievance and Appeal Coordinator and a ValueOptions eligibility representative attend the conference at the offices of ADHS/DBHS. At that time, ADHS/DBHS utilizes their Grievance and Appeal Department staff to mediate and the conference is facilitated in the same manner as the Informal Conference, with an emphasis on exploring any new information that may have been attained in the period between conferences that would possibly assist in case resolution. Appeal cases regarding all other populations, including consumers appealing SMI eligibility decisions, are forwarded to the Fair Hearing level if resolution is not obtained in the first informal conference.

Appeals at the Fair Hearing Level
If there is no resolution of the issue at the Informal Conference Level for RBHA Appeals, the case is forwarded for a fair hearing. At that time, the ValueOptions' Grievance and Appeal Attorney who represents ValueOptions at the fair hearing reviews the appeal. Depending on the case, the Attorney forwards an introduction letter to the consumer that includes a reminder to the consumer about advocacy services available to the consumer. We maintain an appeals calendar to ensure the proper representation of ValueOptions at the hearing.

The Attorney maintains statistics as to the number of cases, type of case and the resolution of each case so that trends may be monitored. The data is sent to the Grievance and Appeals Manager to coordinate with the Clinical Department to enhance the provision of services and evaluations.

The Attorney works very closely with the treating clinician or physician advisors to address potential informal resolution prior to the fair hearing. As additional information becomes available prior to the hearing, the case is evaluated for potential resolution. For SMI eligibility determinations, physician advisors review the new medical records as they become available to determine if a denial should be reversed.

Grievance Investigations for Consumers with a Serious Mental Illness
As required by A.A.C. R9-21-401 et seq. and in accordance with ADHS/DBHS policies, ValueOptions conducts investigations when a complaint involves potential rights violations for consumers with a serious mental illness. For persons with a Serious Mental Illness, the ValueOptions grievance process examines any allegations that a rights violation or a condition requiring investigation has occurred. The Grievance and Appeals Department takes the necessary steps to protect the health, safety and security of any person determined to have a serious mental illness, witness or individual filing the grievance. The grievance process serves as a means for identifying system deficiencies and developing corrective action plans to resolve any deficiencies identified. After receiving a grievance or request for investigation, a decision must be made to either summarily dispose of the Grievance/Request, e.g., if the complaint is filed outside timelines; dispose without investigation, e.g., if there is no dispute as to facts; or conduct an investigation pursuant to the A.A.C. rules.

Should the Grievance and Appeals Department receive a complaint that does not fit within the scope of the grievance process as defined in the A.A.C. but may be fairly resolved informally, the Grievance and Appeals Department will assist the consumer with the desired resolution. All Consumers also have access to an informal dispute resolution process through the Customer Service Department as described in section *Volume 1j* of this proposal.

ValueOptions' Grievance and Appeals Department employs a full–time Investigator. The Investigator conducts a fact-based investigation that includes interviewing the consumer and other fact witnesses. The Investigator gathers all necessary documentation, including information from the medical record with close supervision by the Grievance and Appeal Manager.

The conclusion of the investigation process is provided in a written report that is submitted to the Grievance and Appeal Manager. The report outlines findings concerning the consumer's rights relating to the reported incident and recommendations. Those recommendations are included in a written letter to the consumer that describes the findings and recommendations.

If the consumer does not agree with the conclusion of the investigation, the consumer has the right to request an Administrative Review of the Investigation Report by ADHS/DBHS. ADHS/DBHS may then support ValueOptions' findings or may remand the investigation back to ValueOptions with a recommendation of further investigation.

If an allegation has been substantiated through the investigation process, the Grievance and Appeals Department requires corrective action from the agency or department responsible for the rights violation. Possible corrective actions may include a request for training, policy development/change, and request for employee supervision, monitoring requirements, recommendation for employee disciplinary action or referral of findings to professional licensing boards.

Handling of Complaints for SMI Consumers with TXIX
Customer Services is available to handle all consumer complaints for this population when received by telephone or in writing. If consumer requests an appeal or if a ValueOptions Customer Service Representative identifies the complaint involves an appealable issue, the representative forwards the complaint in writing to the Grievance and Appeals Department. In addition to the rights previously outlined for consumers with a Serious Mental Illness, ValueOptions adheres to the

requirements under Title XIX and Title XXI that services are to remain in place pending final resolution of the appeal. Appeals are filed verbally or in writing. The consumer, their representative or ValueOptions' staff completes the ADHS/DBHS Complaint Form with all necessary information.

ValueOptions provides all Title XIX and Title XXI eligible persons the opportunity to appeal specified actions that a behavioral health provider may initiate. When a behavioral health provider takes an action as defined by the ADHS/DBHS Provider Manual, the behavioral health consumer receives timely notice, allowing them to exercise their right to appeal a decision. The notices are provided in accordance with ADHS/DBHS required timeframes. The behavioral health consumer has up to 60 days from the date the notice of action is mailed to file a standard appeal.

For persons with a Serious Mental Illness, benefits can continue during the appeal process. The appeal will be expedited only if the consumer, or behavioral health provider filing on behalf of a consumer files an appeal before the later of 10 days from the mailing of the notice of action (as per ADHS/DBHS Provider Manual Section 5.1, Member Notice Requirements) or the intended date of ValueOptions' action. If expedited, resolution is expected within three business days, unless the consumer has requested an extension of the timeline or the consumer has accepted the RBHA's extension request. Additionally, the consumer's benefits may continue if the appeal involves the termination, suspension or reduction of a previously authorized course of treatment. In this case, an authorized behavioral health provider must have ordered the services, the original period covered by the original authorization had not expired and the behavioral health consumer requested a continuation of benefits. The originally authorized benefits will continue to be extended during the appeal process until the behavioral health consumer withdraws the appeal, the AHCCCS Administration issues a State fair hearing decision adverse to the behavioral health consumer, or the time period or service limits of a previously authorized service has been met. Additionally, the benefits will not continue if the behavioral health consumer does not request a state fair hearing indicating that he or she wants continued benefits within 10 days of ValueOptions or ADHS/DBHS mailing of the appeal resolution notice.

Handling of Complaints for Non-SMI/Title XIX Consumers
Customer Services is available to handle all consumer complaints for this population when received by telephone or in writing. If consumer requests an appeal or if a ValueOptions Customer Service Representative identifies the complaint involves an appealable issue, the representative forwards the complaint in writing to the Grievance and Appeals Department. With exception to the continuation of service benefit for persons with a Serious Mental Illness, the process described in the preceding paragraph for SMI/Title XIX individual applies to non-SMI/Title XIX consumers.

Handling of Complaints for Non-SMI/Non-Title XIX Consumers
Customer Services is available to handle all consumer complaints for this population when received by telephone or in writing. If consumer requests an appeal or if a ValueOptions Customer Service Representative identifies the complaint involves an appealable issue, the representative forwards the complaint in writing to the Grievance and Appeals Department. These consumers are usually referred to as General Mental Health/Substance Abuse consumers. This population is entitled to appeal decisions regarding covered services, provided the service is available to other consumers in the region. The appeals process described in the paragraph describing the SMI appeal process applies to this population, with the exception that the informal conference at the DBHS level is not available.

Handling Provider Complaints
The Grievance and Appeals Department facilitates the Provider Appeal process as outlined in the ADHS/DBHS Provider Manual, Section 5.4. This process affords behavioral health providers the opportunity to challenge an adverse action or decision by ValueOptions that impacts the provider. Examples of events that behavioral health providers may appeal to ValueOptions include the partial or full denial of payment of a claim, the non-payment of a claim and the assignment of sanctions. Appeals are filed within 60 days of the date of the adverse decision or policy.

Within five days of receiving the notice of appeal, ValueOptions will notify the provider in writing that the appeal has been received, will be reviewed, and a decision will be issued within 30 days of receipt of the appeal. An extension of this timeframe may be requested and the provider must agree to it in writing. Following research involving the participation of the ValueOptions Claims and Clinical Operations Departments, a written final decision will be hand delivered or sent certified mail to the provider. The final decision letter includes:

- a statement of the nature of the appeal;
- the issues involved;
- affirmation or reversal of the adverse action, decision or policy; and
- a statement of the reasons for the decision with references of the statutes, rules and policies involved; and
- a statement that a provider dissatisfied with the decision may request an administrative hearing by filing a request with the ADHS/DBHS Office of Grievance and Appeals within 30 days of receipt of the decision. If the case is forwarded to an administrative hearing, each party provides the necessary professional, paraprofessional and administrative services used by each respective party.